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AN EVALUATION OF PARTNERSHIP IN
THE DEVELOPMENT OF STRATEGIC
HEALTH POLICY

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Abstract

This PhD analyses strategic health partnerships, focusing on Health Improvement Programmes (HIMPs) and Health Action Zones (HAZs). It is a case study of four English health districts, based on 81 semi-structured interviews, and on partnership documents and observations. Partnership – central to New Labour’s modernisation agenda for the NHS – was intended to improve the quality of health services and reduce health inequalities. This thesis conceptualises three dimensions of partnership – *co-ordination*, *collaboration*, *participation*. It uses three theoretical frameworks to interpret the nature of partnership in the study sites.

Governance Theory – market, hierarchy and networks - provided a framework to conceptualise the broader context in which partnership was developed but also to explore the influence of central government on local statutory agencies. Over-use and poor co-ordination of central command and control tools strengthened hierarchical relations. Coupled with a shift towards healthcare delivery, this undermined the development of autonomous, lateral relationships.

Resource Dependency Theory provided a framework to analyse the influences on horizontal relationships between local partners. This theory sees actors as self-interested, manipulating the environment to enhance their resources while reducing their resource dependency on others. A model was developed to explain how resource motivations and symmetry combined with local circumstances to shape partnerships.

Collaboration Theory provided a normative framework to assess the quality of the partnership process. According to this theory, innovative and consensual solutions to social problems emerge through inclusive processes – often involving conflict and requiring impartial facilitation. In the study sites, these processes were constrained by overbearing hierarchical relations and local influences, resulting in policy co-ordination, not radical innovation.

The thesis argues that government reforms resulted mainly in partnership as *co-ordination*. Partnership as *participation* marginally increased while partnership as *collaboration* was barely evident. The shift from market to networks was undermined by the government's strengthening and (mis)management of hierarchical relations.

Acknowledgements

I would like to thank my Supervisor, Dr Naomi Fulop, and members of my Advisory Committee, Dr Judith Green and Professor Ewan Ferlie for their guidance and support. I am also grateful to Leroy White for his advice, encouragement and enthusiasm, and to North Thames Region Research and Development Research Fellowship for funding this research. I would like to thank my family for being so supportive, tolerant and understanding throughout the years of research. In particular, my heart felt thanks go to my partner, Helen Collinson, whose loving support ensured I completed this thesis.

Finally, I would like to thank all the people in my study sites who kindly agreed to be interviewed and let me observe their meetings. The research would not have been possible without their willing co-operation.

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Chapter 1 – Literature review

1.1 Introduction

This thesis is about the strategic health partnerships that were created to improve health and reduce inequalities in the English National Health Service (NHS). It is based on comparative case studies of partnership in four district health authorities (HAs).

It seeks to understand the nature of partnership between health authorities and other statutory and non-statutory agencies, such as local authorities (LAs) and the voluntary sector¹, in the production of local health strategy. The following questions are addressed: what factors influence the development and functioning of partnership? How do these factors influence behaviour and interaction of partners, and what impact does this have on the development and outcome of partnership? These questions are considered in the context of the government's ambitions for strategic health partnerships.

It uses Health Improvement Programme (HImPs) and Health Action Zone (HAZs) partnerships as a focus for research. These were new strategic health partnerships conceived and initiated by the New Labour government shortly after it came to power in 1997. As part of the agenda to modernise public services, their purpose was to encourage greater collaboration and innovation between organisations in order to tackle the wider health issues facing local communities and reduce the inequalities in health between different population groups. Partnership was one of the key concepts that underpinned New Labour's organisational reforms to the NHS. It was a major theme in government policy as a whole, which in turn was rooted in their philosophy of the 'Third Way'. This argues that in order to meet the challenges posed by fundamental changes in society such as inequality, government needs to become, amongst other things, more democratic, transparent, participatory and efficient. Partnership was seen

¹In this thesis the term voluntary sector is used in its broadest sense in that it includes users/carers, community groups and the public and not just voluntary organisations. Where greater precision is required each individual term is used.

as one means of addressing these needs and public health an appropriate area for its application.

The thesis conceptualises three dimensions of partnership encapsulated in the government's policy documentation and Third Way philosophy – co-ordination, collaboration and participation. These dimensions are explored using three theoretical perspectives from different academic disciplines, as there is no one comprehensive theory of partnership.

Organisational Economics theories of governance conceptualise the co-ordination of public (and private) services in terms of markets, hierarchy and networks. This perspective provides an analytical framework for the thesis as a whole but also for exploring the influence of central government on the development and outcome² of strategic health partnerships.

Resource Dependency Theory provides a framework to analyse and understand the influences on relationships between local partners. This theory sees actors³ as self-interested, manipulating the environment to enhance their resources while reducing their resource dependency on other organisations. A model is developed to explain how resource motivations and resource symmetry combined with local circumstances to shape partnership development.

Collaboration Theory provides a normative framework against which the quality of interactive processes in partnership is assessed. According to this theory, innovative and consensual solutions to difficult social problems emerge through negotiations involving conflicting perspectives and requiring inclusive and impartial facilitation.

²In common with other case studies on partnership, this thesis uses the term outcome to signify the process output of partnership i.e. involving communities, resource allocation, policy and initiative development etc, rather than the impact on population health. The term 'health outcome' is used when the latter sense is required.

³In this thesis the term actor(s) is used to signify both organisation(s) and the individual(s) which are located within them.

These theoretical perspectives are reviewed in more detail in this chapter. Chapters 3, 4, 5 and 6 present the findings, with reference to the theoretical perspectives. Chapter 7 summarises the findings and discusses their implications with reference to each theoretical perspective. The findings are contrasted with the model of partnership outlined in government policy and the governance framework on which it draws. Policy recommendations are made, areas of further research identified and the strengths and weaknesses of the study discussed.

Chapter 1 begins by reviewing and defining the concept of partnership and its dimensions. The three theoretical perspectives relevant to the study of partnership are then explained and assumptions discussed. This is followed by a review of empirical literature on health partnership and an analysis of its deficiencies in addressing partnership. The context of health partnership in the UK is then outlined, first providing a brief history of health partnership in the UK, then by examining the philosophy of the Third Way, on which New Labour's impetus for partnership was predicated, and finally giving an overview of reforms to the NHS (and other public services) structured around two key themes – partnership and performance management. The distinguishing characteristics of New Labour's health partnerships are outlined and some underlying tensions and assumptions explored. Finally, the questions addressed in this thesis are set out. The research methods and strategy used to study these questions, together with their rationale and justification, are set out in Chapter 2.

1.2 Towards a definition of partnership

It is crucial to clarify exactly what is meant by the term 'partnership' before embarking on any thesis to evaluate strategic health partnerships. This section explores the language associated with partnership and some of the underlying concepts. A model of partnership which encapsulates key aspects of the government's conceptualisation is then outlined.

1.2.1 Partnership – a clarification of terms

In the context of health policy, definitions of partnership are rare (Taket 1999); its meaning is often left implicit, while a host of terms associated with partnership are used, often interchangeably. These include ‘inter-agency working’, ‘multi-professional’, ‘trans-sectoral’, ‘alliance’, ‘collaboration’, ‘co-operation’ and ‘networks’. This has led to a terminological quagmire (Leathard 1994). Rawson has attempted to clarify matters by separating the terms used into three concepts (Rawson 1994):

1. Problematic association: inter/multi/trans
2. Grouping: agency/sectoral/professional/occupational/alliances
3. Focus of operations: collaboration/co-operation/integration/teamwork/joint working

In so doing, he unravels three important aspects of partnership.

1. *Problematic association* relates to the nature of linkages between those participating in joint work. Different terms have different connotations. For example, ‘inter’ denotes a relationship between and among partners and so implies some notion of reciprocity; whereas ‘trans’ and ‘multi’ signify relationships across and beyond partners without any indication of mutuality (Leathard 1994; Rawson 1994).
2. *Grouping* relates to who is included in a partnership. Terms such as ‘agency’ and ‘sector’ emphasise organisational features of relationships, perhaps to the exclusion of community groups or individuals, whereas the terms ‘professional’ or ‘occupational’ signify an ideological allegiance and perhaps more exclusive membership (Rawson 1994).
3. *Focus of operations* draws attention to the way in which partners work together. A variety of labels are used here such as *networking*, *co-operation*, *co-*

ordination, collaboration, often indiscriminately in policy documents. However, they have subtle but important differences in meaning which are explored below.

Networking, for example, is an informal relationship between organisations, usually at the level of the individual. Individuals exchange information and resources for benefit. There is no formal linkage between organisations; commitment and risk-taking is low and maintenance of organisational autonomy high.

Co-operation is a more formal form of working together without any commonly defined mission, structure or planning effort. Organisations co-operate in order to achieve their own goals (A1, B1) (see Figure 1.1). Authority is retained by each organisation, reducing the risk as resources and rewards are kept separate (Mattessich and Monsey 1992). It is a more temporary type of interrelation.

Co-ordination, on the other hand, is broader in scope. It is a specific form of joint working, directed towards the achievement of a common objective (C1 in Figure 1.1) in a systematised and managed manner (Collins 1994). It is often based on formal, contractual agreements in which *joint* goals and activities are set out with a clear definition of task and structural linkages between agencies (Mulford and Rogers 1982). The process of co-ordination involves more resources and, as a consequence, staff of greater seniority (Mulford and Rogers 1982; Collins 1994). Interaction involves higher organisational integration and, therefore, places greater restrictions on autonomy.

As some theorists use the terms co-operation and co-ordination conversely to those above (see Himmelman 1996), Table 1.1 focuses on a number of underlying criteria to distinguish between them.

In public administration, co-ordination can be similarly conceptualised although the emphasis is generally more on enforced hierarchical control over local statutory

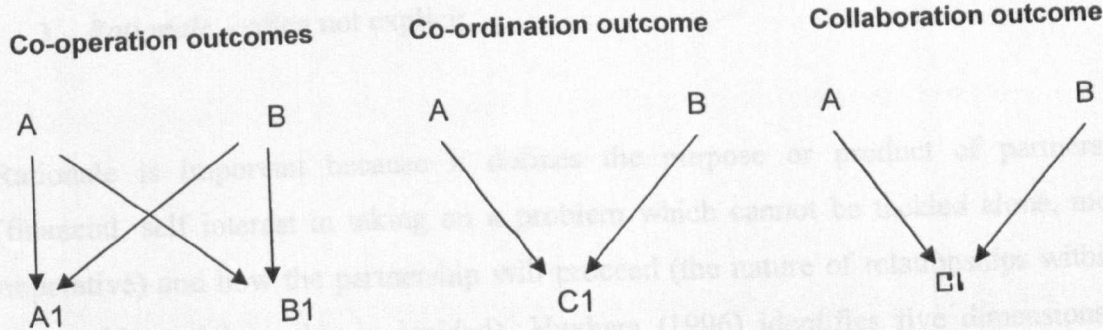
Table 1.1. The difference between co-operation and co-ordination.

Criteria	Co-operation	Co-ordination
Rules and formality	No formal rules	Formal rules
Goals and activities emphasised	Individual organisations' goals and activities	Joint goals and activities
Implications for vertical and horizontal linkages	None, only domain agreement	Vertical or horizontal linkages can be affected
Personal resources involves	Relatively few – lower ranking members	More resources involved – higher ranking members
Threat to autonomy	Little threat	More threat to autonomy

Source: (Rogers 1982, pp.13 Table 2.1)

organisations (*mediated* co-ordination) than on voluntary interaction (*unmediated* co-ordination) (Kickert and Koppenjan 1997). Mediated co-ordination has two forms akin to *imperative* and *collaborative* co-ordination (Challis, Fuller et al. 1988). *Imperative* co-ordination involves the process of centralised rational planning to provide a coherent framework to guide action at a lower level (Challis, Fuller et al. 1988). It is vertical and obligatory (Kickert and Koppenjan 1997).

Figure 1.1. Difference between co-operation, co-ordination and collaboration



Source: adapted from (Rogers 1982)

Collaborative co-ordination, or collaboration by comparison, is about local organisations working with others towards common goals on a joint project or initiative which is mutually beneficial (Mattessich and Monsey 1992; Huxham 1996; Means, Brenton et al. 1997). It is an intense form of mutual attachment, involving exchanging information and sharing resources, responsibilities and risks (Mattessich and Monsey

1992). The degree of integration and formalisation can be high, with the establishment of new structures and a commitment to a common mission. However, others frequently do not specify the degree of linkage (Himmelman 1996), emphasising instead the *process* of working together (Gray 1985). Managing the process of interaction in a way that handles differences constructively can result in innovative solutions to joint organisational problems that lone stakeholders could not have conceived (□ in Figure 1.1) (Gray 1989; Gray 1996).

The terms used above to describe the *focus of operations* have three common elements (Huxham 1996, pp.8):

1. *Mode of organising* – intensive and mutually beneficial. The benefit may not be in society's interest; hence the sometimes pejorative use of 'collaboration' to signify working traitorously with an enemy (Pratt, Plamping et al. 1998).
2. *Structural form* – with varying degrees of integration or closeness between organisations or individuals. Figure 1.2 indicates how the degree of organisational integration relates to the focus of operations.
3. *Rationale* – often not explicit.

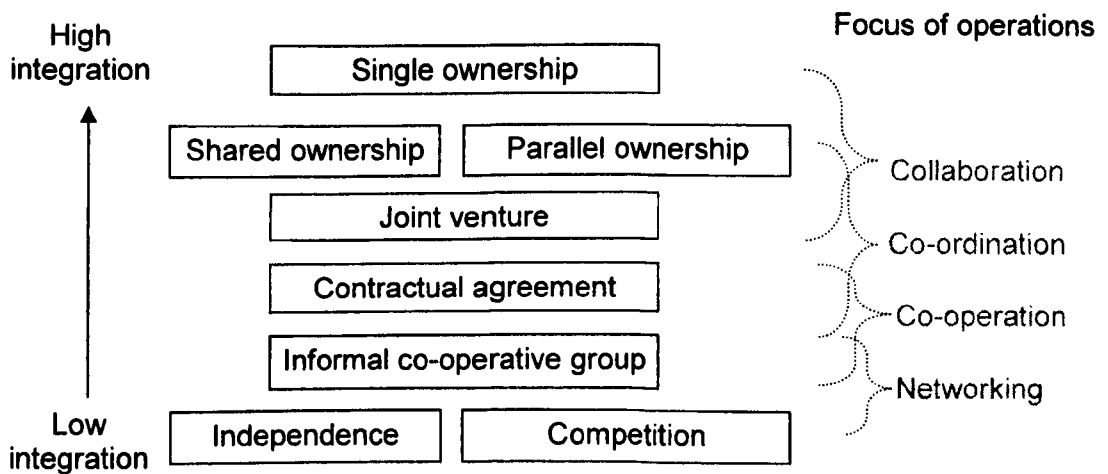
Rationale is important because it defines the purpose or product of partnership (financial, self interest in taking on a problem which cannot be tackled alone, moral imperative) and how the partnership will proceed (the nature of relationships within a partnership and how this is decided). Huxham (1996) identifies five dimensions of rationales which interrelate to varying degrees in non-linear ways:

1. *Empowerment and participation*
2. *Power relationships*
3. *Addressing conflict*
4. *Substantive change* (advancing a shared task or vision)

5. *Ambitiousness* (information exchange or joint agreements)

Dimensions are instrumental in that partnership is seen as a vehicle to achieving a particular purpose or satisfying ideological needs.

Figure 1.2. Structural models of interaction between managed care organisations and public health agencies



Source: adapted from Halverson (1997)

As will be shown later in the chapter, a number of these rationales clearly resonated with the view of partnership expressed by New Labour.

The next section considers partnership as a mode of participation, as it is key to the conceptualisation of partnership.

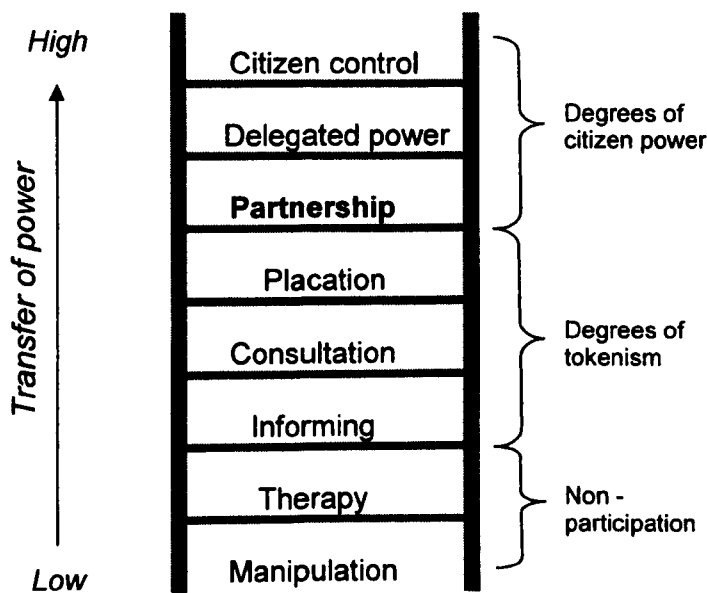
1.2.2 Partnership as a mode of participation

This perspective emphasises the nature of relationships between stakeholders, in particular, the degree to which power and control is shared (Popay and Williams 1998). Many of the models and concepts of participation were developed with voluntary sector involvement in mind, where people and organisations were viewed as a resource for innovation and change, not a source of problems (Cameron and Cranfield 1998, pp.11).

Cadbury defines partnership as ‘an involved form of participation’ in which power is shared equally between all partners (Cadbury 1993). This definition is differentiated from more passive degrees of participation, such as *consultation*, where views are listened to but not necessarily heard when making a decision. The ability to influence through consultation is therefore limited. Similarly, Wilcox identifies partnership as a mode of participation in which different interests, *acting together*, decide what is best (1994). Unless decision-making is handed over to *independent community interests* to decide how to allocate resources, there is a danger of manipulation, paternalism and even coercion of this sector unless issues of participant power are addressed.

Arnstein (1969) explicitly recognises this issue in her classic model of participation. Writing about community involvement in the War on Poverty programme in the USA, she describes an eight-step ladder of participation (see Figure 1.3). *Partnership* represents a level of participation where planning and decision-making responsibilities are shared i.e. through joint committees. This implies a degree of equality amongst partners. However, partnership represents the lowest level of *citizen power*. Higher modes of participation involve greater voluntary sector representation to the point (idealised) at which citizens control the entire decision-making process. Participation at a level less than partnership is tantamount to *tokenism* or *non-participation*. In these models, levels of participation appear linear, one-dimensional and static – implying that different modes do not concur at the same time or shift with time. Although useful in recognising the need to move the balance of power on resource decisions towards the community, how this relates to innovation is not delineated. There is also a naïve assumption that increased representation and equality between partners will address imbalances in power. However, there are other dimensions to power which can influence decisions beyond the decision-making forum (Bachrach and Baratz 1962; Lukes 1974). Furthermore, these models do not explicitly address empowerment. As Oakley (1999) notes, there are two distinct interpretations of participation. The first one is *participation as empowerment*. This relates to the acquisition of skills, knowledge, experience and confidence that enable the community to take greater responsibility for their development (i.e. involvement in and ability to influence decision-making).

Figure 1.3. Arnstein's ladder of participation



Empowerment is not only seen as an instrument of change which can help to reverse social exclusion but also one which can lend legitimacy to change (Bartunek, Foster-Fishman et al. 1996; Croft and Beresford 1996; Oakley and Kahssay 1999). The second interpretation is *participation as collaboration*, a means to ensure effective development and implementation of initiatives to address complex problems, as discussed above. These are not soluble by any one organisation and are therefore not their sole property. Individuals, organisations or communities that are directly affected by the problem also have a stake and therefore can legitimately claim a right to influence the decision-making process (Gray 1989).

Conceptualising partnership as a distinct mode of participation is useful as it draws attention to the extent of voluntary sector involvement in, and influence over, the decision-making process. This is not only dependent on the empowerment of individuals, groups and communities but also requires a shift in power relations towards the voluntary sector.

1.2.3 Partnership as co-ordination, collaboration and participation

For this thesis, I define partnership as:

'a mutually beneficial and well-defined relationship entered into between two or more stakeholders (individuals, groups or organisations) to achieve a common goal.

It involves a commitment to: mutual relationships and goals, a jointly developed structure and shared responsibility, mutual authority and accountability for success and sharing of resource and rewards.'

(Adapted from Mattessich and Monsey 1992)

However, for greater analytical specificity I employ the notion of partnership as *co-ordination*, *collaboration* and *participation*. This is because these three concepts were identified either implicitly or explicitly in government thinking/policy on partnership, as will be shown in Section 1.5.3. In this conceptualisation, partnership can be seen as a way to improve *co-ordination* between the different parts of the state (national and local) and their delivery of public services, reducing duplication and inefficiencies. It can also be seen as a *collaborative* process whereby local stakeholders, through a process of resolving conflicting perceptions and values, generate innovative solutions to difficult social problems. Finally, partnership can be understood as a mode of *participation*, with the voluntary sector actively engaged in, and having influence over local decision-making and resources.

This conceptualisation fits well with a number of different theoretical perspectives considered relevant to strategic health partnerships. These are explored next.

1.3 Theoretical frameworks

There is no single theory of partnership (Gray and Wood 1991). Instead, a variety of perspectives have been employed to explore different aspects of partnership (preconditions, processes and outcomes) or related concepts, i.e. networks (Reitan 1998; Ferlie and McGivern 2003). These include economic organisation theories, corporate social performance theory, strategic management theory, institutional theory, leadership

and organisation theory, organisational science, sociology of knowledge, policy implementation theories; psychology and post-modern perspectives (Gray and Wood 1991; Bartunek, Foster-Fishman et al. 1996; Lichtenstein, Alexander et al. 1997; Reitan 1998; De Leeuw 1999; Lawrence, Phillips et al. 1999; Rosenhead and Mingers 2001a; Exworthy, Berney et al. 2002). I draw on three theoretical perspectives to understand health partnership:

1. Governance Theory/Organisational Economics
2. Policy networks/Resource Dependency Theory
3. Collaboration Theory

As will be shown, Governance Theory was chosen as it provides a useful framework to conceptualise the broader context of change in social policy, including recent reforms to the NHS and other public services (Barzelay 2001). It can also be used to analyse partnership as an organisational form (Lowndes and Skelcher 1998). Policy networks/Resource Dependency Theory was chosen as it provides a link between national and local context and behaviour in networks or inter-organisational relations, helping to understand what factors drive or influence interaction. Collaboration Theory was selected as it specifically focuses on the process of partnership and how relations can be actively managed to achieve desired outcomes. Although the first two theories relate to networks/inter-organisational relations, the ideas and concepts they contain can be applied to partnerships, which, as noted in Section 1.2.1, are more formalised and instrumentally structured than networks. In addition, each theory focuses on a different aspect of partnership in a complementary way (context, interaction and outcome); they can also accommodate the different conceptualisations of partnership (i.e. *co-ordination*, *collaboration* and *participation*); and the literature on each is reasonably developed with respect to health partnership. The three theories are therefore useful in addressing one or more of my research questions.

Each theory is now outlined and its relevance to health partnership explored in the context of government reforms.

1.3.1 Governance Theory/Organisational Economics

Coordination

This perspective focuses on how organisational life can be governed or 'steered' (Pierre and Peters 2000). Co-ordination can be understood in terms of three idealised models – markets/competition, hierarchies/bureaucracies and networks/associations/clans (Bradach and Eccles 1991; Ouchi 1991; Thompson 1991a; Øvretveit 1993; Collins 1994; Flynn 1996) – each of which is explained in more detail below.

These models can be used to conceptualise how organisations such as the NHS co-ordinate and allocate resources in the production of goods and services. This might involve one or a combination of the three models. A central concern is which model or mix of models is the most efficient for producing a service. In the public sector, this question needs to go beyond considerations of technical efficiency, addressing whether a service is also sensitive to peoples' needs and responsive to their demands.

i. Market or competition. Markets or competition is the simplest mechanism of co-ordination and the easiest to sustain. It determines what to produce, how it should be produced and for whom (Flynn 1996). It requires no agreement between competitors or indeed communication (Pratt, Plamping et al. 1998), as exchange of goods or services between individuals or organisations is mediated by means of price signals. Markets are driven by self-interest. To be efficient there has to be genuine competition and incentives between participants. Individuals or organisations must know their preferences and interests and be able to act freely on them. Ideally, providers seek to maximise their profits, purchasers are fully informed and knowledgeable, there are several providers with no barriers for entry into the market place, and no external costs to production that could influence the behaviour of the purchaser (Donaldson and Gerard 1993; Lipsey and Chrystal 1995). If these conditions do not exist, as is often the case in health care, markets will fail to co-ordinate efficiently.

In the public sector, co-ordination involves participants willingly exchanging resources in order to attain higher levels of collective welfare. Exchange may involve a variety of

‘commodities’, such as clients or information, and is not just limited to money and contracts – although cash incentives may be used to ensure co-ordination (Nocon, Small et al. 1993). Indeed, the creation of the internal market in the NHS in 1991, with the separation of purchasers and providers of health care, was based on theoretical assumptions of the market (Flynn 1996). The rationale for adopting this model was that the market would achieve greater efficiency in allocation and co-ordination of resources, whilst improving quality, innovation and responsiveness through consumer choice. Contracts therefore replaced command as the prime mode of co-ordination (Ferlie and Pettigrew 1996). However, the shift to a full market-based mechanism was never completed (Exworthy, Powell et al. 1999).

ii. Hierarchy or bureaucracy. Co-ordination cannot always be left to the ‘invisible hand’ of the market. Market failure can result in exchange activities having to be consciously organised and co-ordinated in hierarchical organisations or bureaucracies (Francis, Levačić et al. 1991).

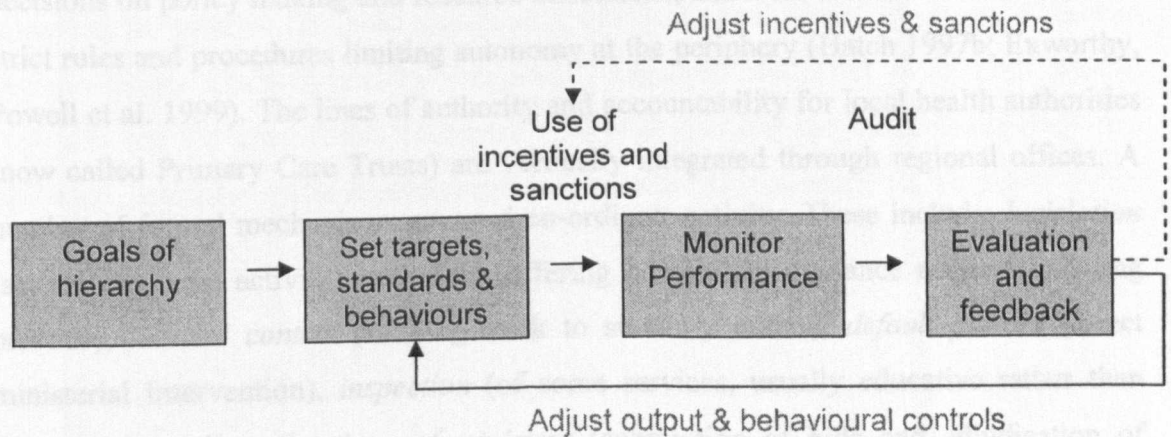
Bureaucracy is ‘a hierarchical organisation designed rationally to co-ordinate the work of many individuals in the pursuit of large-scale administrative tasks and organisational goals.’ (Weber 1964). Bureaucracies have a high level of structural complexity and formalisation (rules and regulations) but are decentralised (Hatch 1997a). Organisational goals are achieved through the sub-divisions of tasks and use of specialist skills. Activities are integrated and co-ordinated through command and control mechanisms. Using rational management techniques, superior officers send commands down the vertical structures for implementation by lower ranking officers (Mitchell 1991; Collins 1994). The use of rules and regulations helps ensure that distractions from achieving organisational goals – individual emotions and interests – are minimised (Haralambos and Holborn 1990a; Øvretveit 1993). Co-ordination is achieved by *routinised* activity (division of labour, operational rules etc) or through government *mandate* (Webb 1991). Control is effective because it is founded on rational-legal authority; commands are therefore considered legitimate (Haralambos and Holborn 1990a).

Critics of bureaucracy point to three issues which undermine its ‘technical superiority’: *efficiency*, *rationality* and *power* (Morgan 1990a; Thompson and McHugh 1995). In practice, its structure produces numerous *inefficiencies* or dysfunctions as it stultifies initiative, slows down decision-making and makes officials inflexible and insensitive (Greenwood and Wilson 1989; Jan-Erik Lane 2000). This is because officers’ work becomes ‘ritualised’, sometimes rigorously applying the rules as a means of work avoidance (*bureaucratic behaviour*) (Hatch 1997b). Alternatively, bureaucrats bend rules to get work done more efficiently. Either way, the claim of bureaucrats working *rationally* to achieve organisational goals is undermined. Nor are hierarchical structures or specialisation necessarily functional to organisational goals, as both can encourage groups to extend their own influence and discretion or *power* (Thompson and McHugh 1995). Critics claim that, over time, bureaucrats develop new goals to serve sectional interests, displacing the formal objectives of the organisation. This adds to bureaucratic inefficiency. Certainly the tension between the legitimate needs of individuals and the demands of the formal organisation are not taken into consideration in the Weberian model of bureaucracy (Jan-Erik Lane 2000). Indeed, many studies have identified an ‘implementation gap’ between the commands issued by hierarchy and the actions of ‘street-level bureaucrats’ (Elmore 1997; Hudson 1997; Exworthy, Berney et al. 2002).

Nevertheless, neo-Weberians advocate alternative forms of bureaucracy (Thompson and McHugh 1995). These models recognise that centralisation and hierarchical control are less suited to the work of professionals, experts and managers which requires autonomy (Thompson and McHugh 1995). They therefore recommend decentralisation of operational work and greater discretion to lower-level sub-ordinates (Hoggett 1997). In large, complex organisations, co-ordination is achieved through blending hierarchical control and sub-ordinate discretion in decentralised sub-units – a process that is called *suboptimisation* (Elmore 1997). Control is achieved by focusing on the performance of sub-units rather than on the technical details of work practices or activities (Elmore 1997; Hoggett 1997). Optimal performance is managed through the use of *output controls*. These focus on measuring task activity of individuals or teams (using targets or indicators) and require outputs to be easily measurable (Hatch 1997b). When this is not the case, hierarchies may prefer to employ *behaviour controls* (Hatch 1997b). These rely on identifying behaviours linked with high performance, and become standards

against which individuals can be evaluated. They may be development or procedural (Hoggett 1997). Monitoring of performance, through audit or appraisal, for example, is central to the use of controls, allowing activity or behaviour that deviates from organisational goals to be identified and corrected.

Figure 1.4. Systems model of hierarchical co-ordination and control



(Adapted from Hatch 1997b)

One powerful tool for managing performance is the creation of incentives (additional resources) and sanctions (financial penalties or termination of contract) in order to encourage attainment of the goal desired by the hierarchy (Fleisher 1991; Hatch 1997b). These harness the self-interested behaviour of actors. Figure 1.4 presents graphically this rational-systems approach to co-ordination and control in hierarchy (Hoggett 1997). The approach assumes that targets and standards used not only reflect hierarchical goals but are measurable.

Some activities are extremely difficult to measure (*ambiguity*) (Hatch 1997b) and therefore difficult to reward or sanction. Monitoring may produce a negative reaction, leading to greater concern with satisfying the system rather than attaining a particular goal (*goal displacement*). This may create a good but wrong impression or result in cheating, as demonstrated by the use of output controls in the NHS (Gulland 2003; Jackson 2003; Kmietowicz 2003). Furthermore, the ‘enormous amount of time’

involved in administering performance management (Hoggett 1997) may draw resources away from achieving organisational goals, undermining its effectiveness (Power 1997).

In the UK, government departments are organised according to the bureaucratic characteristics outlined above, albeit with some variations (Greenwood and Wilson 1989). In the NHS, there is a central, controlling executive at its apex, taking strategic decisions on policy making and resource allocations, and a decentralised structure, with strict rules and procedures limiting autonomy at the periphery (Hatch 1997b; Exworthy, Powell et al. 1999). The lines of authority and accountability for local health authorities (now called Primary Care Trusts) are vertically integrated through regional offices. A number of formal mechanisms are used co-ordinate activity. These include: *legislation* (setting out legal activity), *circulars* (offering advice and guidance rather stipulating practice), *judicial control* (limiting work to statutory duties), *default powers* (direct ministerial intervention), *inspection* (of some services, usually educative rather than coercive), *appellate functions of ministers* (submission of bids and adjudication of disputes) and *finance* (regulating and scrutinising expenditure) (Greenwood and Wilson 1989; Leach and Percy-Smith 2001a).

Over the past two decades the government has increasingly relied on output and behavioural controls to co-ordinate activity in addition to input controls. Increased operational decentralisation and devolved management (i.e. Trusts) following the creation of the internal market in the 1990s, was accompanied by substantial developments in performance management and monitoring (also linked to incentives and sanctions). This innovation led to two new strategies for control: managed competition and sub-optimisation. The former strategy represented a ‘hands-off’ approach to control, the latter, with its strong emphasis on output and behavioural controls, was essentially a reassertion of a bureaucratic mechanism, albeit indirect (Hoggett 1997; Ranade and Hudson 2003). New Labour’s reforms sought to shift the balance of control strategies again.

iii. *Network or association.* Networks are an alternative approach to co-ordinating people, agencies and transactions besides markets and hierarchy (Øvretveit 1993). These are non-formalised relationships between social actors with complementary interests (Nohria and Eccles 1992a). Co-ordination is achieved by informal, more egalitarian and co-operative means in order to pursue valued interests or objectives (Thompson 1991b). It is based on friendship, kinship or ethnic relationships, within and across organisational boundaries (Machado and Burns 1988; Collins 1994; Bogason and Toonen 1998). Individuals and organisations are not self-interested utility maximisers operating in isolation (as conceptualised in classical economics) but are embedded in social relations characterised by *mutuality*, *reciprocity* and *trust* (Thompson 1991b; Lowndes and Skelcher 1998). These are vital to developing and maintaining long-term exchange relationships and deterring conflict and ‘malfeasance’ (Granovetter 1985; Lomi and Prevezer).

Mutuality implies that network members have a common interest or gain benefit from participation. *Reciprocity* implies members give resources with the expectation of receiving something in exchange, either immediately or in the longer term. Resources may be tangible such as financial, human or informational, or intangible where membership of a network may enhance reputation or kudos. *Trust* is the relational bond that allows members to work towards a mutually beneficial goal. It represents the degree of certainty that other members will accomplish their contribution to that goal, when there is no way of monitoring their action (Kirkpatrick 1999). Trust allows for a more open and reliable exchange of information (Ebers 1997). When combined with reciprocity it enables concerted action to continue (even when unspecified in contracts) and the sharing of risks, encouraging innovation and change.

Control in networks is regulated through social and cultural means, such as losing the right to expect things from others, loss of reputation, shame and exclusion from the network (Øvretveit 1993; Lowndes and Skelcher 1998). Members are, therefore, subject to considerations of power (Powell 1991; Flynn 1996)

Networks and other informal patterns of association have been identified as influential features of the public policy arena for several decades (John 1998). On health issues, informal policy networks have been identified in community care, alcohol and tobacco policy (Harrison and Tether 1987; Hardy, Wistow et al. 1990; Read 1992). At a local level, health promotion partnerships have been described as networks as stakeholders have no formal authority and resources are exchanged through a process of negotiation and bargaining (Delaney 1994). Formal networks arguably exist between health and social services, through central government's creation of Joint Consultative Committees (JCCs). HImP and HAZ partnerships could therefore be considered as formalised network structures to improve health and reduce inequalities.

iv. Integrating the three modes of co-ordination All three of the above modes of co-ordination have been identified in public and private sector organisations. Lowndes (1998) argues that all forms coexist, with different modes coming to the fore at key stages of organisational development. However, there is no single, accepted view of how these idealised organisational forms 'work' to produce co-ordination (Francis, Levačić et al. 1991). And nor is there a coherent theoretical model which explains how characteristics of mutuality, reciprocity, and trust interact and unfold over time in different types of networks (Newell and Swan 2000; Vangen and Huxham 2003).

Transaction Cost Economics is one perspective which seeks to link two of the modes - markets and hierarchy (Williamson 1975). This theory helps to explain the conditions under which each mode is more efficient at producing a service or product. The driving explanatory mechanism is related to a product's transaction cost – the informational monitoring costs associated with the production of a good. The theory, however, has little to say about mode of organisational operation or development, failing to take account of more convincing and comprehensive accounts of human behaviour or organisational theory (Morgan 1990b; Parsons 1995). Other theorists such as Powell (1991) have adapted the theory to include networks, in response to a rapid growth of small entrepreneurial, high tech firms linked by networks (Johnston and Lawrence 1991; Snow, Miles et al. 1993; Kirkpatrick 1999; Taket and White 2000a). Central to Powell's explanatory mechanism is the presence of trusting relations in networks. These

reduce the need to monitor behaviour and keep transaction costs low. However, there are few analytical tools with which to investigate the role of trust in networks (Mannion and Smith 1997, pp.144; Zaheer, McEvily et al. 1998). This deficiency is confounded by different disciplines characterising different types, quantities and bases of trust (Saad, Rowe et al. 1999; Korczynski 2000; Vangen and Huxham 2003).

Although there is no one accepted theory of governance which unifies the three modes of co-ordination, the broad concepts it contains are useful in understanding strategic health partnerships in two ways: first, as an overarching contextual framework to conceptualise the development of strategic health partnership. New Labour's Third Way philosophy and their subsequent reforms were couched in terms of market, hierarchy and networks. Partnership (formal networks) was preferred over managed competition as its main mode of co-ordination. Second, government reforms stressed indirect hierarchical controls to steer partnership (performance management).

I therefore use Governance Theory to understand the context in which health partnerships were established. I also use hierarchy as a framework to explore the influence of central-local relations on the development and functioning of local strategic health partnerships. In particular, Chapter 3 uses this framework to explore the impact of NHS command and control mechanisms on the structure and process of health partnership, and on the achievement of the organisational goals of health improvement and reduced inequalities.

Given that the governance perspective generally resorts to a characterisation of networks rather than provides a substantive theory for their development and functioning, this thesis draws upon the policy networks perspective, which, as an explanatory model of inter-organisational relations, is better developed.

1.3.2 Policy Networks and Resource Dependency Theory (RDT)

This perspective focuses on how policy-making in the public sector is influenced by policy networks. The structural nature of policy networks and the degree of integration

into government is accredited with shaping policy outcome (Smith 1997). The existence and influence of policy networks have been identified in political and policy science literature for a long time (Klijn 1997; John 1998; Leach and Percy-Smith 2001b).

Indeed, it is argued that government is increasingly dependent on policy networks to develop and co-ordinate policy and deliver public services, at the expense of formal institutions (hierarchy). Throughout the 1980s, there has been a marked shift from line bureaucracies to decentralised service delivery, incorporating voluntary and private sectors in new networks (Rhodes 2000a). This has resulted in a 'hollowing-out of the state' as internal fragmentation has limited the capacity of the core executive to steer, resulting in greater dependence on indirect controls to manage and co-ordinate activity (Pierre and Peters 2000, pp.45; Leach and Percy-Smith 2001b; Ferlie and McGivern 2003).

In the UK, an explanatory model for policy networks has been developed by Rhodes (1988a; 1992) and Marsh (1998). It draws heavily on Resource Dependency Theory (RDT) (Pfeffer and Salancik 1978) and Benson's (1975; 1982) political economy framework, rather than formalised methods for assessing networks (Pfeffer 1997, pp.63).

This 'power-dependence' model analyses inter-organisational networks at three levels: the micro level, focusing on bargaining tactics and negotiative behaviour of agents in networks; the meso-level, exploring inter-organisational dependencies, resource exchange and power relations; and the macro-level, focusing on the structure of power and interests in society. The macro-level provides the context for the lower level analysis (Sanderson 1990). RDT essentially provides the theoretical framework for the micro and meso level analysis, explaining the impetus for the development of inter-organisational relations (uncertainty) as well as their nature (power) (Pfeffer 1997, pp.63).

RDT starts with the assumption that no organisation is able to generate all the resources it needs to achieve its goals, or is able to perform all the activities necessary to make it self-sustaining. Organisations are therefore dependent on the environment for resources (Hall 1996). At the micro level, organisations engage with other organisations, accessing the scarce resources they need, including markets for their products or services, through negotiation and exchange. This process reduces organisational uncertainty and is undertaken as long as it does not threaten organisational interests (Pfeffer 1997). Resources are considered in the broadest sense (financial, political, informational, clients etc, including intangibles such as legitimacy, although ultimately in human service agencies these boil down to money and authority) (Benson 1975). The assumption is that actors are able to identify uncertainty, are aware of other potential partners and are capable of assessing how their interests will be served (Gulati 1999). According to RDT, organisations act as rational, utility maximisers, entering into external relations when benefits of exchange are perceived to outweigh the costs. This reckoning will include the transaction costs associated with exchange (Challis, Fuller et al. 1988, pp.40).

Organisations therefore develop structures around access to resources (Burke 1995), and attempt to manage the environment to their own advantage (Hall 1996), working with better-resourced organisations to secure their interests while also trying to preserve their relative autonomy (Hardy, Wistow et al. 1990; Oliver 1991; Wood and Gray 1991; Parsons 1995). Since the control of resources is discretionary, different types of inter-organisational relations can develop and a network of dependence and interdependence emerges. The nature of dependencies is determined by the degree of need for a resource, i.e. its centrality to organisational survival, but also by access to alternative sources (substitutability) (Scharpf 1978; David and Zakus 1998). When there is low need and high substitutability, relations are *independent*. When an organisation has a high need for a resource, with few or no alternatives, *high dependence* arises. Conversely, when resources are of low importance but there is low substitutability, there is *low dependence*. When similar levels of dependency relationships exist between organisations, there is *mutual dependency* (symmetry). However, when there are asymmetrical relations (high-low dependency) between organisations, *unilateral dependency* arises. In RDT, power is a function of dependence (Cook 1982). The nature

of symmetry in dependency relations, therefore, is an important driver of the dynamics of inter-organisational interaction and has implications for co-ordination. Where dependence is asymmetrical, co-operative exchange may occur on terms dictated by the organisation which controls the critical resources. Lack of compliance may jeopardise access to resources. Where relations are more symmetrical, with resources spread more equally among the partners, power or influence is more balanced. Interaction is more likely to be characterised by compromise, negotiation and sharing of resources (Phillips, Lawrence et al. 2000). However, symmetrical dependence can also generate mutual vulnerability where each party is concerned not to upset each other. This may lead to the evolution of 'rules of the game' or a 'zone of legitimacy', limiting the range of objectives and the means used in influencing strategies, and constraining co-ordination (Scharpf 1978).

However, the resource climate in which dependencies form and develop is likely to influence relations and behaviour, as it will not only affect supply and access to resources but also perceptions of need. Organisations operating in a resource-scarce environment or with a small or declining resource base are likely to have different perceptions of need for resources and opportunities that exchange might bring. For example, in asymmetrical relations, more powerful organisations may seek influence or control over sought-after, scarce resources by exercising their dominance over less powerful organisations (Oliver 1990), while weaker organisations may accordingly shy away from interaction, seeking alternative resources (Challis, Fuller et al. 1988). On the other hand, weaker organisations may seek to increase the reciprocal dependence of the other partner, transforming the relationship into one of mutual dependence (Scharpf 1978).

The perception of the need for resources (and loss of autonomy), the nature of inter-organisational relations (symmetry) and environmental context interact, resulting in a complex network of dependency relations. The nature and dynamism of relations is a result of actors' attempts, through power-gaining and power-balancing mechanisms to alter the network and redistribute power (Cook 1982).

In the provision of human services, provider networks become highly co-operative when interaction between organisations is based on normative consensus and mutual respect (Benson 1975). This is not only dependent on a *positive evaluation* of other organisations' work (i.e. is it valued) and patterns of *work co-ordination* or co-operation between organisations to provide a service (i.e. multi-agency team work and resource dependencies and base) but also *domain consensus* (agreement about role and scope of agencies) and *ideological consensus* (agreement of the nature of tasks and techniques of intervention). The latter two are important because money flows into organisations based on activities. However, for networks to co-ordinate effectively, all four components need to be in balance, with improvements (or decline) in one dimension bringing improvements (or decline) in others.

The relative power of an organisation in a co-operative network is dependent on its access to and control over critical resources as well as its position (centrality) (Benson 1975). These in turn will be influenced by an organisation's links with different interest and ideological groups in society. At a macro level, these relationships influence control over the flow of resources into a network as well as organisational activities (Mulford 1984; Sanderson 1990). Networks are therefore shaped by the dominant political and economic interests in society, whose systems of beliefs, values, assumptions and ideologies (such as capitalism) limit the choice and behaviour of policy-makers and ensure that some demands are excluded from the decision-making process (Parsons 1995). These also shape actors' cognitive patterns and social behaviour through a process of institutionalisation (Klijn and Teisman 1997; Börzel 1998). In the UK, for example, the medical profession is highly integrated with the Department of Health (DoH), its curative model of medical practice exerting a strong hegemony over policy development and resource allocation with regard to health and sickness (Challis, Fuller et al. 1988; Hardy, Wistow et al. 1990; Wistow 1992). Nevertheless, there is scope for government to manipulate networks by changing the rules (through legislation) and by altering resource flows (and, therefore, resource dependencies and network position) in order to achieve the desired co-operation or co-ordination between organisations.

The literature on RDT is large and long-established, its roots extending back into the 1960s with early work based on theories of resource exchange. Rogers (1982) and Mulford (1984) have summarised this and more recent research on resource dependency in the human services partnerships (mainly in the USA). In their view, resource exchange is positively correlated with scarcity of resources, domain consensus, lack of alternative resources, and goal similarity. Inter-organisational conflict is positively related to scarcity of resources, lack of alternative resources, and goal similarity but is negatively related to domain consensus. Mulford (1984) concludes that mutual dependence, more than asymmetric dependence, is positively correlated with exchange. Although he is generally supportive of the RDT, he asserts that only a small percentage of the overall variance in these quantitative studies is explained by these independent variables (Mulford 1984). A more recent retrospective study of the voluntary sector in the USA found that loss of autonomy appeared to be less of a deterrent when entering into partnership than RDT would predict (Oliver 1991). However, many of these studies failed to consider wider environmental influences on inter-organisational ties. Nearly all the studies were: cross-sectional, and therefore unable to assess the development of inter-organisational relations with time; ahistorical; and quantitative, using measures of poor or unknown validity or reliability (Rogers 1982; Hall 1984; Molnar 1984).

A review by Halpert (1982) of the antecedent factors facilitating co-ordination between human service organisations, identified a host of interpretative factors broadly similar to those identified by Benson (positive evaluation, domain consensus, recognition of mutual independence etc). However, unlike previous studies Halpert correlates actors' interpretation of the context with these factors (see Appendix A). Logsdon's (1991) study of environmental collaborations identifies two interpretative prerequisites that are essential: an *interest* or stake in the outcome of an inter-organisational relationship, and *interdependence* on other organisations for either resources or in dealing with a particular social problem. Similarly, Oliver's (1990) review identifies six critical contingencies for inter-organisational relations which are interpretative: *necessity*, *stability*, *legitimacy*, *asymmetry*, *efficiency* and *reciprocity*. The first four are primarily shaped by external factors, efficiency by internal and transaction costs, and reciprocity by the relative properties of organisations. Helling (1998), for example, shows that representatives from different organisations or sectors (employer-sponsored and self-

sponsored (voluntary)) have different perceptions of the value and costs associated with inter-organisational relations.

Few studies, however, link interpretative determinants with contextual factors to explain why organisations choose to enter into exchange relations with one another (Halpert 1982; Oliver 1990; Marsh 1998) or how the structure of the network in which an organisation is embedded may influence relations (Fleisher 1991; Reed 1992, pp.78). Consequently, the interface between the micro, meso and macro-levels of analysis is not clearly distinguished or adequately explored (Rhodes and Marsh 1992, pp.12.). One means of addressing this point is to use a dialectical approach in which structures and interpersonal relations are seen to act and interact (Marsh 1998).

Challis's (1988) in-depth study of local collaboration in six health authority districts in the UK is one of few that blends interpretative and contextual factors within a resource dependency framework. It identifies eight factors in the *primary co-ordinative environment* which form the context of interaction: five *structural* factors (resource base, service stock (size), political factors, complexity of locale and planning and policy issues) and three, less influential, *behavioural* factors (personalities, professional outlook and planning philosophies). It also identifies a number of secondary level environmental variables which relate to the costs and benefits of the process (rather than structural conditions). These interpretative variables relate to the individual and organisational (administration, resources and domain) and provide the dynamic force driving the formation of relations. Challis (1988) argues that in the public sector, medium-sized organisations, with a steady resource-base and in symmetrical relationships are best placed to collaborate, as organisations see the possible benefits while being able to withstand potential resource losses.

Despite being based on only a few simple premises concerning motivation, RDT is useful in exploring the pre-conditions of inter-organisational relations and the factors driving interaction (Wood and Gray 1991). Strategic health partnerships set up by New Labour can be conceptualised as (formal) policy networks, not only for developing local policy on health improvement and inequalities but also for influencing local resource

allocation. Given that the new partnerships were to involve a wide range of stakeholders of varying size and resource dependency relationships, RDT provided a useful framework for understanding the nature and dynamics of horizontal relations in partnerships.

I use RDT in two ways: First, as the framework to explore how external and interpretative factors interact to influence involvement in health partnership in Chapter 4. Second, to investigate the nature of interaction and power differentials in these developing partnerships in Chapter 5. What influence did partners have over resources in health partnership? Were smaller, more resource-dependent organisations able to exert any influence over the decision-making process? In this way, partnership *as participation* could be assessed.

The weakness of RDT is that it is a functionalist perspective, assuming different parts of an organisation work together harmoniously to achieve an organisation's aim. It is also crudely deterministic in that organisations are considered 'victims' of their environment, influenced and constrained by inter-organisational networks (Reed 1992). Interaction is therefore driven by a focal organisation's perception of its environment. There is little accounting for the active management of relations once links are established (Fleisher 1991). RDT, therefore, does not adequately address the process of partnership development (Wood and Gray 1991). It fails to recognise that actively managing interaction can help ensure outcomes do not end in rivalry but in mutual benefit (Jackson and Stainsby 2000).

Collaboration Theory provides a way of addressing this gap, linking the management of partnership relations to the outcomes of the partnership, as discussed below.

1.3.3 Collaboration Theory

The third framework used to analyse and understand partnership is Collaboration Theory (CT) (Gray 1989; Gray and Wood 1991; Gray 1996). This focuses on the active structuring and management of interaction or *process* in partnership in order to address

complex social problems. In contrast to the previous theoretical perspective, which emphasised inter-organisational relations as a means of tackling organisational uncertainty, the focus of CT is on achieving innovation or synergy – collaboration's unique advantage (Huxham 1996; Lasker, Weiss et al. 2001).

CT is founded on Negotiated Order Theory (Strauss, Schatzman et al. 1963; Gray 1989). This views relationships as negotiated by stakeholders in a social context. Working requires the co-ordinated participation of people, who have different levels of training and competencies, values and interests (Hasenfeld 1992). Order is shaped through this self-conscious interaction of participants who are embedded in their own social worlds (Strauss, Schatzman et al. 1963; Gray 1989). Negotiation determines what gets done and how, and this in turn depends on how actors perceive an issue and what priority they give it. As new events occur or actors are encountered, order can be renegotiated and reconstituted. This fluid process may result in more than a modification of an old established order (Nathan and Mitroff 1991). Problems, therefore, are socially constructed and their resolution through negotiation can lead to a new negotiated order.

CT is concerned with the process of finding solutions to difficult social problems, such as reducing inequalities in health. These *meta* problems are a result of rapid socio-economic, cultural and political change in society and are characterised by uncertainty, complexity and unclear boundaries (Taket and White 2000a). Their resolution is beyond the capacity of single organisations to solve. They require organisations to pool their expertise and resources in a process of collaborative decision-making (Trist 1983; Taket and White 2000a). Addressing meta problems first requires organisations to perceive the problem as mutual and to recognise that its resolution can come through collective negotiation and action (Phillips, Lawrence et al. 2000).

Collaboration is a process of negotiation in which stakeholders explore their preconceived conceptual understanding of the problem (Gray 1989), and in-so-doing constructively reconstitute the boundaries and understanding of that problem (Marcus, Dorn et al. 1995). This process involves stakeholders sharing appraisals and perceptions

of the problem, and of what is possible (activities, technology etc), redefining their understanding to arrive at a new *shared* appreciation of the problem (Trist 1983). As a consequence, new solutions emerge which are not only legitimate but unique in that no single organisation could have arrived at it on its own (Trist 1983). Novel or innovative solutions can be classified as *incremental* or *radical* (Roberts and Bradley 1991). Incremental innovation results from first order change; the solution is only a refinement or marginal improvement within the existing normative order. The exchange of information and resources leads to better use of or increased access to resources (financial, informational, technical) (Craig and Taylor 2000) or co-ordination. Radical innovation or synergy (Lasker, Weiss et al. 2001), on the other hand, results from second order change or qualitative alteration to the normative order. This results from a shift in partners' underlying perception of the problem rather than solely from improved co-ordination of information and resources (Roberts and Bradley 1991; Craig and Taylor 2000).

Conflict is central to the process of generating radical innovation (Huxham 1996) as it involves actors with different views and assumptions challenging each other as well as themselves, and renegotiating a new frame of reference.

Managing and resolving conflict is therefore crucial to performance (Webb 1991; Kickert, Klijn et al. 1997a; Kickert, Klijn et al. 1997b). Group interaction needs to be structured and managed to ensure negotiations are productive. Gray (1989), identifies three phases to structuring: problem-solving, direction setting and structuring (self regulation), while Klijn (1997) identifies two elements: *game management* and *network constitution*. In essence, these approaches focus on managing *cognitive* (information, values, beliefs and ideas) and *social* (group interaction, politics/interests and institutional arrangements) processes (Schuman 1996) – although in reality they are inter-related.

Managing cognitive negotiations involves *problem-solving* and *consensus-building*. Problem-solving involves the process of 'reframing', requiring actors to see what hitherto they have not been able or willing to perceive (Schaap and van Twist 1997;

Hoggett 2003). The melding together of judgements of reality and value in a search for a solution that goes beyond any single stakeholder's vision of what is possible demands adroit and sensitive management of conflicting cognitive processes (Trist 1983; Gray 1989, pp.5). For example, resolving conflicting perceptions might in part be due to the lack of a common language (Termeer and Koppenjan 1997). It requires a focus on the content of perceptions as well as the processes through which perceptions are arrived at. It might include furthering a common language or encouraging self or critical reflection. For partners with 'cognitive fixations', the introduction of new ideas and information or an 'authoritative' third party voice can help to break the deadlock (Termeer and Koppenjan 1997).

Cognitive structuring also requires consensus-building so that there is not just a shared appreciation of the problem but joint ownership of the solution. Negotiating the way in which the problem will be dealt with before tackling its content, i.e. the rules and roles (normative framework) for the governance and management of the partnership, can be helpful (Gray 1989; Termeer and Koppenjan 1997; Jackson and Stainsby 2000).

Social relations also need to be managed. Individuals come to collaborations with a mixture of different interests or positions (individual, organisational and professional) and in a context of competing internal and external managerial priorities and political interests. Furthermore, established ways of working together and inter and intra-organisational dependencies and institutional arrangements create a social order within the group. Depending on the depth of feeling about a problem, these interests may be openly voiced or hidden. Arriving at a new negotiated order entails renegotiating this social order. As new solutions may prioritise some interests over others (Eden and Ackerman 2001), tensions may arise between powerful (and less powerful) actors and their competing interests. Careful management or social structuring is required, as unresolved tension can undermine the goals of collective action, leading to indifference and disengagement from the process or the vetoing of solutions (Hardy 1999; Jackson and Stainsby 2000). Management also needs to consider how to develop partnership structures which relate to the institutional arrangements (structures and resources) in which actors are embedded and might seek to change (Klijn and Teisman 1997).

Although no one structure is ideal for all tasks, 'tinkering' with existing structural elements may be preferable to creating new structures as it builds on existing social capital.

Management of cognitive and social negotiations needs to be facilitative, since membership is voluntary and actors can walk away (Ranade and Hudson 2003). A key element is ensuring just procedure (Eden and Ackerman 2001). Communicative interaction – whether dialogue, discussion or debate – needs to be constructive, fair, inclusive, transparent, and equal (Marcus, Dorn et al. 1995; Kickert, Klijn et al. 1997b; Taket and White 2000b; Eden and Ackerman 2001). Conducting collaboration in this way can help reduce anxiety associated with conflict, encouraging all participants to contribute, argue and challenge freely (Hoggett 2003). It can also help generate commitment, ownership and trust between members, ensuring actions are followed through (Cropper 1996). Without a just process, innovative outcomes are less likely (Eden and Ackerman 2001). Indeed, imbalance in the negotiating process may lead to compromise or coercion (Phillips, Lawrence et al. 2000), with the 'agreed' outcome being imposed on others by a more powerful partner. Such interaction does not represent negotiation, rather an exertion of the first dimension of power (Lukes 1974).

There is ample evidence that inter-organisational arrangements are often difficult to manage (Huxham and Vangen 2000a). In response, a number of systems management tools have been developed to assist with the structuring and management of collaboration, focusing on improving group process (social) and the 'content' of discussions (cognitive) (Huxham 1996; Taket and White 2000a; Eden and Ackerman 2001; Rosenhead and Mingers 2001b). The use of an external facilitator, with collaborative management expertise but no authority or vested interest in the outcome, can help steer collaboration towards the generation of synergy (Schuman 1996; Hoggett 2003).

However, achieving a negotiated consensus is also influenced by the size and diversity of group membership. This presents a paradox: the very differences which enable a group to 'think' in new ways (radical innovation) – a wide array of perspectives, values,

views, skills and interests – also increase the likelihood of conflict and the task of managing a new negotiated consensus more difficult (Turcotte and Pasquero 2001). Large, diverse groups, together with changing membership and ambiguous and complex structures can undermine the interactive process, creating inertia (Huxham and Vangen 2000a). Even with a well-facilitated process, achieving radical innovative solutions to difficult social problems is a rare outcome of collaboration. Negotiations are more likely to be characterised by compromise rather than a radical shifting of perspective. Therefore, the outcome of partnership is likely to be incremental – albeit accompanied by improved mutual understanding and working relations (Rosenhead and Mingers 2001a).

New Labour very much framed strategic health partnerships in terms of collaboration, with their focus on tackling the difficult social problem of health improvement and inequalities and their emphasis on stakeholder inclusion and innovation, as is shown in Section 1.5.3. I use CT as a normative framework to evaluate HImP and HAZ partnerships in Chapter 6. Key characteristics of the hypothesised process required to generate radical innovation – good communication, conflict, procedural justice, consensus – are used as evaluative benchmarks. This contributes to an assessment of partnership *as collaboration*.

The weakness of CT is that it paints an over-optimistic, even altruistic picture of actors' nature (their willingness and capacity to engage), their ability to see other perspectives and reframe their mindset, and the role of conflict. In reality, actors are reported to be rather more 'pessimistic' and self-interested in nature (Challis, Fuller et al. 1988). Furthermore, too much emphasis is accorded to micro-level processes. This understates the higher levels of organisation – organisational structures, enforced institutional patterns of interaction and the environment – which can greatly limit the context and nature of negotiations (Hasenfeld 1992). CT is based on conflicting perspectives and interests but it fails to consider adequately power in its different guises and its influence on the collaborative process (Hardy and Phillips 1998). Nevertheless, CT does provide a complementary perspective to the two preceding theoretical frameworks.

This section has reviewed three theoretical frameworks which have been used to understand health partnership: Governance Theory, Resource Dependency Theory and Collaborative Theory. Each perspective is based on different assumptions, focuses on different aspects of the structure, process and outcome of partnership and applies at different levels of analysis. Together they provide a powerful set of frameworks with which to analyse and evaluate HImP and HAZ partnerships. The next section reviews and synthesises the empirical evidence on health and other social welfare partnerships.

1.4 Empirical evidence on health partnerships

This section reviews the empirical literature on partnerships in health and health care and social services, primarily in the UK. A summary of the evidence relating to facilitators and barriers to health partnership is presented. The approach to the literature search and some of the issues and difficulties faced are discussed in Appendix B on page 356.

UK evidence on health partnerships

In general, the literature on health partnership in the human service and welfare field in the UK is limited to descriptive empirical studies, reflective observations or to anecdotes on how improvements to inter-organisational working could be made. Research on the effectiveness or cost-effectiveness of joint working appear to be virtually non-existent (Douglas 1998).

The search strategy employed a variety of terms outlined in Section 1.2, focusing on databases covering the health and social science literature to identify evaluative studies on strategic health partnerships in the UK (see Appendix B). These mainly concerned partnerships linked to the HImP and HAZ initiatives, the Health of the Nation strategy, and the World Health Organization (WHO) Healthy Cities and Health for All 2000 initiatives.

Studies identified were predominantly based on case study methodology and used qualitative data collection methods (Carruthers, Shapiro et al. 1999). A few studies used cross-sectional survey as their data collection strategy (Rathwell 1992; LGA 2000;

Geller 2001), while others used content or documentary analysis (Judge, Barnes et al. 1999; Barnes, Sullivan et al. 2001; Elston and Fulop 2002). One study used observational and audit methods (Carlisle, Shickle et al. 2004). Only a handful of studies used a theoretical perspective for their research on partnership. One pan-European study on Healthy City partnerships (including a UK case study) was based on three theoretical frameworks – Gray’s Collaboration Theory, Gusfield’s theory on the culture of public problems and Kingdon’s theory on process streams in policy (agenda, alternatives and public policies) (De Leeuw, Abbema et al. 1998; De Leeuw 1999). One study on pre-1997 health inequalities partnerships used Pettigrew’s (1992a) theory of receptive and non-receptive contexts for change (Evans and Killoran 2000), while another used a framework which analysed the *consequential* and *constitutive* value of partnership (Knight, Smith et al. 2001). One study of HImP strategies also used Kingdon’s theory on process streams (Exworthy, Berney et al. 2002). The majority of studies associated with the national HAZ evaluation used Realistic Evaluation (see methods chapter) and Theories of Change (Bauld, Judge et al. 2000; Lawson, Mackenzie et al. 2002). These methodologies advocate using theory to hypothesise causal links between context, process and outcome, although the national evaluation did not specify which theories might be appropriate. Furthermore, the focus of most of these studies was on policy evaluation – what works, when and where – rather than on understanding partnership *per se* or furthering its theoretical understanding. The limitations of this methodological approach in evaluating complex social processes such as partnership has subsequently been recognised (Sullivan, Barnes et al. 2002; Barnes, Matka et al. 2003). A summary of the findings of these studies is presented in Appendix C (Table C1 and C2) on pages 359 and 371.

In addition to studies on strategic health partnerships, several empirical studies on local collaborations between health care and social services (such as the JCCs) were identified. Most of these studies took an interpretative approach to understanding partnership but few used a theoretical perspective or concepts in their analysis, with the notable exception of Challis (1989). This was the most comprehensive study identified and draws heavily on Resource Dependency Theory (see Policy Networks in Section 1.3). A summary of the findings of these studies is presented in Appendix C (Table C3).

The review also identified a number of studies on partnerships established to improve housing, the local economy or environment (i.e. City Challenge and SRB partnerships), and involving similar organisations to health and welfare partnerships (Roberts, Russell et al. 1995; Geddes 1997; Wilson and Charlton 1997; Arblaster, Conway et al. 1998; Gregory, Crossley et al. 1998; Lowndes and Skelcher 1998).

Before summarising the research on health partnership, a brief overview of research on HImP and HAZ partnerships is presented and its relevance discussed.

Evidence on HImP and HAZ partnerships

The majority of HImP studies identified were undertaken during their first year and focused on issues and difficulties partnerships faced in this formative period (Arora, Davies et al. 1999; Carruthers, Shapiro et al. 1999; NHS Executive London Regional Office 1999; Arora, Davies et al. 2000), or analysed the content of HImP strategies in relation to specific priority areas, such as CHD (National Heart Forum 1999), children's health (National Heart Forum 1999; NSPCC and the Children's Society and the National Children's Bureau 1999; Underdown and Sexty 2000), obesity (National Audit Office 2001), or against national guidance (Abbott and Gillam 2000), partnership structures and processes (Elston and Fulop 2002). One study investigated the implementation of the HImP strategies within health authority commissioning (Carlisle, Shickle et al. 2004). Although the limited research on HImPs has been summarised (Hamer 2000; Marks and Hunter 2000) and reviewed by a group of parliamentarians (All Party Parliamentary Group on Primary Care and Public Health 2000), no in-depth, theoretically grounded studies of HImP partnerships were identified.

The majority of the research on HAZ partnerships was from the national evaluation (Bauld, Judge et al. 2000; Lawson, Mackenzie et al. 2002). Using mainly interviews, observation and documentary analysis, interim and on-going evaluation reports and studies have analysed HAZ strategies and identified difficulties, issues and emerging lessons on themes such as partnership working and voluntary sector involvement (Judge, Barnes et al. 1999; Amery 2000; Unwin and Westland 2000; Barnes, Sullivan et al. 2001; Crawshaw, Bunton et al. 2003). Others have evaluated perceptions of local

impact and success criteria of projects (Sullivan, Judge et al. 2004) or the impact of projects on HAZ objectives such as partnership (Cole 2003).

The findings of the research on HImP and HAZ partnerships, while based on sound evaluative methodologies, do not draw on theories of collaboration, networking or inter-organisational relations and are not set within explanatory frameworks. The findings have therefore been incorporated with other empirical research on health partnership below. However, where appropriate they have been used throughout this thesis to support its conclusions and extend their generalisability to other locations.

The empirical evidence identified in the literature search reveals a growing consensus about core factors considered to influence partnership, whether it is to improve health, health and social care, the local economy or environment, or whether it involves a broad range of statutory and non-governmental organisations (NGOs) or individuals. These have been broadly summarised into two broad categories, although these should not be considered mutually exclusive. They relate to the *structural and environmental context* in which partnership operates and the *process* of partnership.

The *structural context* of the partnership can influence resource flow, decision-making processes and co-ordination of activities, while *environmental context* sets the broader constraints in which partnerships operate. *Process* relates to the management of *interaction* between partners and the structuring of the *content* of the decision-making process. Evidence relating to these two categories is discussed next.

1.4.1 Context

The structure of partnership and the environmental context in which it takes place can also have a strong influence over the development of partnership.

Structure and structural context

The literature is not prescriptive about organisational structures required for successful partnerships, although the influence of structure on interaction has been recognised by

some researchers. Hardy (1992) identifies four types of structure in health and social care provision that have been attributed to improving inter-agency co-ordination:

- i. The creation of a single organisational framework by merging health, social care and other services to provide a fully integrated, multi-disciplinary service located in one body. There are few examples in the UK, although such a structure is similar to the government's proposed 'Care Trusts'.
- ii. A dedicated project leader, funded co-ordinator or joint appointment to act as a single point of contact. This can facilitate communication within a partnership. A co-ordinator also needs to have considerable 'reticulist' skills in order to 'network' between organisational and professional boundaries (Webb 1991). Likewise, health strategy and health promotion partnerships have identified the important contribution of a co-ordinator (Scriven 1995; Bloxham 1996; Green 1998).
- iii. Decentralised control of resources. This can enable flexible deployment of resources tailored to meet individual needs (Challis 1989).
- iv. A common or joint budget to fund individual care packages. This approach can allow greater flexibility in the deployment of resources at a local level, helping to reduce areas of service overlap and duplication (Higgins, Oldman et al. 1994).

While formal joint planning structures can be useful in bringing parties together to exchange views and explore the possibilities of joint work, structure alone is not sufficient to ensure effective collaboration (Challis 1989; Nocon 1994). Strong political and organisational opposition can create difficulties when trying to establish a common care budget, even when a partnership has tacitly agreed to do so (Higgins, Oldman et al. 1994).

Organisations' different timetables make integration of commissioning and planning structures difficult (Hudson 1997). Commitment and leadership from senior staff working on operational as well as strategic issues are therefore important (Delaney and Moran 1991; Webb 1991). However, if progress is to be made, senior management must have sufficient authority to be able to commit time, energy and resources to the partnership (Davies and et al. 1993).

The number of partners and their geographical boundaries and responsibilities may also make a difference to the ease with which participating organisations and individuals can co-ordinate activities (Douglas 1998). Coterminosity between HAs and LAs may reduce the number of statutory agencies involved in the partnership, but its absence certainly does not preclude partnership (DoH 1998a).

Finally, ambiguity and complexity in partnership structure and changing membership can lead to 'collaborative inertia' (Huxham and Vangen 2000a).

Environmental context

A number of studies identify the wider political environment as playing an important role in encouraging and maintaining inter-organisational work (Davies and et al. 1993; Scriven 1995; Bloxham 1996; DoH 1998a). Lack of government commitment can be a major obstacle to securing effective partnerships at local level (Delaney and Moran 1991), while supportive central policy and resource streams can encourage their development.

Central policy. Government public health and health promotion initiatives (i.e. on sexual health) such as the Health of the Nation were reported as facilitators of collaboration between HAs and LAs, whether located in schools or the wider community (Scriven 1995; Bloxham 1996; LGA 2000). However, a lack of coherence or direction from government can undermine joint work (Denman 1994). This was a factor limiting LA involvement in the Health of the Nation strategy (Cornish, Chris et al. 1997; DoH 1998a). Organisational, policy and financial fragmentation of central government inevitably influences the degree of attainable cohesion at local levels

(Hudson 1997). Different departments have different priorities and policy initiatives which impact on health, directly or indirectly, but may not always emanate from the DoH. Such fragmentation, then, can not only lead to a failure to focus on issues of mutual concern, but can also result in the pursuit of diametrically opposed policies (Hudson 1997). Unless synchronicity and co-ordination between central government departments are good, there is scope for inconsistency. The complex and contradictory legislative framework surrounding sex education in the UK as well as government policy on smoking are cases in point (Denman 1994; Green and Delaney 1994; DoH 1998a). Conflict between the goals of these policies and the goals of the Health of the Nation strategy undermined joint work. The failure of the Health of the Nation strategy to influence policy in other departments, despite the then government establishing a special co-ordinating committee to do so, demonstrates the need for effective structural mechanisms to co-ordinate policy within the higher echelons of government. It also demonstrates the importance of political will. New Labour's emphasis on partnership in *Saving Lives*, the *New NHS* and in policy from other government departments, plus the development of cross-departmental (HAZ) units, all encouraged the development of HImP and HAZ partnerships. However, persisting policy incoherence also undermined their development (Carruthers, Shapiro et al. 1999).

Mechanisms to monitor and evaluate implementation of policy at a local level can also provide an important stimulus to statutory agencies to participate in partnerships (DoH 1998a; Carruthers, Shapiro et al. 1999). The lack of a performance management framework was one of the factors that undermined the commitment of senior officers in statutory agencies to implementing the Health of the Nation strategy (DoH 1998a). Heavy, top-down performance management regimes (rather than locally derived frameworks) with a differentiated, operational focus and inconsistent application created tension in HImP partnerships and hindered the development of HAZ partnerships, shifting their focus and undermining local ownership (Arora, Davies et al. 1999; Carruthers, Shapiro et al. 1999; Exworthy, Berney et al. 2002).

Organisational and financial stability. An unstable external environment resulting in changing financial circumstances and large-scale organisational restructuring at local

level can shift the focus away from inter- to intra-organisational pre-occupations. For example, in the 1990s NHS organisations prioritised the reduction of waiting lists and faster hospital discharge procedures over calls for greater inter-agency working on health policy (Hudson 1997). The scope and pace of centrally driven changes to organisational structure, remit and boundaries made the forging of stable relationships for strong partnerships difficult, creating organisational uncertainty (i.e. for HAs, PCGs, CHCs) (NHS Executive London Regional Office 1999), reducing organisational capacity for partnership (Davies and et al. 1993) and undermining it as a priority (Judge, Barnes et al. 1999). These issues were reported in the early development of HImP and HAZ partnerships (Arora, Davies et al. 1999; Carruthers, Shapiro et al. 1999)

Finance. Secure and stable funding to support inter-agency work, while not essential, can go a long way to helping to facilitate partnership (Davies and et al. 1993). Establishing a partnership takes time and requires human and financial resources. Resources are not only useful for the development of innovative projects but also for administering partnership. A number of studies report that the availability of funds to support a partnership co-ordinator can facilitate joint work (Davies and et al. 1993; Nocon 1994; Scriven 1995; Bloxham 1996; Green 1998). Central government funds are not only helpful but can also signal the government's commitment to a policy, especially in times of financial restraint. Earmarked funding can be helpful in supporting the work of health alliances when pressure on resources is tight (Fulop, Elston et al. 2000), although too much specification can work against developing local priorities, as was identified in early studies on HImP and HAZ partnerships

Thus, the external environment in which partnerships are formed can have a profound effect on relationships, structure and the aims of partnership. It can influence power relationships, energy levels and morale; determine what formal structures and mechanisms are set up; and influence resource provision and organisational priorities.

1.4.2 Process

Managing interaction – developing the quality of relationships

Partners need to develop social relationships in partnership at the same time as they focus their attention on the content of the partnership.

Values. Understanding and respecting the values that drive partner organisations can be very important in judging how to plan and manage inter-organisational relationships (Cameron and Cranfield 1998). Values affect not only initial motivation for joint working but also the ability to sustain effort in times of difficulty (Loxley 1997). However, values are often not homogeneous and may vary between organisations as well as within them.

Douglas identifies two value bases, resulting in diverse cultural patterns that can influence the nature of a partnership for health. Organisations may be *people-change* focused, attempting, for example, to change or modify behaviour or beliefs. These organisations tend to have strong *outcome*-orientated values and only value partnership as a means to an end – if it can deliver improved health outcomes or social benefit. When the outcomes of inter-organisational work are not measurable, this can be unsettling to participants and may lead to difficulties. *People-process* organisations, by contrast, hold output values and tend to be more service and organisational orientated, viewing joint working as a reasonable end in itself (Douglas 1998). Discrepancies in underlying value systems can be a major obstacle to joint working (Cornish, Chris et al. 1997).

Cultural differences. Culture is composed of values and beliefs and is expressed through attitudes. These can be expressed explicitly in an organisation's mission statements or implicitly in assumptions and behaviour with the particular culture (Loxley 1997). Different cultures can result in group tension (Pickin, Popay et al. 2002).

There are clear cultural differences and modes of operation between different health and social care organisations. One major difference between HAs and LAs, for example, is the system of accountability. LAs are political institutions and accountability is exercised through the presence of elected representatives (Higgins, Oldman et al. 1994),

whereas accountability in health authorities is managerial – to the chief executive officer (and, ultimately, to the NHS Executive) – or professional.

Differences in collective values and beliefs between these statutory agencies can be identified in their respective documents. An analysis of Community Care Plans by Schofield (1997) found HAs heavily biased towards medical and public health models of needs assessment, while social services plans reflected a client-based perspective with an emphasis on individual needs.

However, statutory organisations are not homogenous internally. Many have multiple cultures (Higgins, Oldman et al. 1994), often stemming from the professional groups from which they are constituted. Different professions socialise members through education, training and practice. These reflect different value systems, knowledge bases, codes of practice, language use and systems of accountability. Many professions do not value partnership or community involvement, for example, valuing expertise over lay experience (Pickin, Popay et al. 2002). Community, voluntary and private sectors value entrepreneurial culture, which can conflict with public sector values of accountability and the accompanying adversity to risk (Pickin, Popay et al. 2002).

The political perspective encompassing organisations or key individuals also reflects different values and beliefs and therefore attitudes towards inter-organisational work. Several studies note how different perspectives can hinder partnership development (Davies and et al. 1993; Delaney 1994; DoH 1998a).

Managing group differences. Unless different values and cultures are explored fully by partnerships and differences resolved right from the start, misunderstanding and misconceptions can arise (Loxley 1997). Partnerships that do not acknowledge these internal differences are likely to be racked by tension and conflict, leading to separatism and rivalry rather than integration and co-operation (Hudson 1997; Cameron and Cranfield 1998)

Overcoming differences and being able to compromise, however, does not happen without the investment of time and effort in exploring different perceptions in an atmosphere of openness, tolerance and trust (Davies and et al. 1993; Huxham and Vangen 1996; Green 1998). Failure to address differences effectively can lead to mistrust and suspicion across organisational and professional boundaries (Loxley 1997), particularly when dealing with the voluntary sector (Taylor 1997). Creating and maintaining trust requires perpetual maintenance and reinforcement by successful outcomes (Webb 1991). Indeed, the level of trust to be developed needs to reflect the ambition of the collaborative project. When the environment is hostile to collaboration, modest, low risk ventures are the way forward (Webb 1991).

Structuring content (problem-solving and managing social relations)

Many empirical studies describe partnership as needing to go through a number of important stages. Structuring the content of partnership and managing its content can help deliver process outcomes, as noted earlier when discussing Collaboration Theory.

A number of normative frameworks were identified in the UK (and non-UK) empirical literature derived from theoretical (Gray 1985; Gray 1989; Loxley 1997; Lowndes and Skelcher 1998) and empirical-based studies (Delaney 1994; Thompson and Stachenko 1994; Scott and Thurston 1997; Douglas 1998). Despite small variations, the content of most frameworks is similar and can be summarised into four stages (elaborated in Appendix D):

- i. An *assessment* of the need for partnership is the first step. Identifying stakeholders and recognising common goals or developing shared goals
- ii. In the *building* phase, the partnership needs to clarify roles and construct relationships (with trust, commitment, empowerment etc) and structures
- iii. This requires the *management* of social relations, agreement and implementation and delivery

- iv. *Evaluation* of partnership (nature of relations etc) and its impact (efficiency and equity), feeding back and learning from the experience, and termination if successful.

Progression through each stage tends to be presented in linear sequence (as above), although some frameworks acknowledge the cyclical, iterative and messy nature of this process (Scott and Thurston 1997; Ariño and Torre 1998).

Developing shared goals. Developing shared goals is frequently recognised as an important factor in facilitating partnership (Hambleton, Essex et al. 1996). However, the feasibility of diverse organisations sharing and agreeing goals is debatable and has been challenged by critics of ‘rational’ models of policy development (Delaney 1994). Nevertheless, it is possible to recognise differences while still sharing a broad commitment to philosophical principles. Recognising that all parties have something to gain and contribute will also help partnership (Nocon, Small et al. 1993; Bloxham 1996; Cornish, Chris et al. 1997; Cameron and Cranfield 1998).

Objectives, on the other hand, do have to be compatible. This is also true of value-systems, political principles and professional ideologies that serve to inform ‘vision’ and operate at an affective level (Nocon 1994; Douglas 1998).

Building. Agreeing the terms of reference (roles, responsibilities and competencies) in the formative stages of a collaborative project is considered crucial to its success (Means, Brenton et al. 1997; Cameron and Cranfield 1998).

Managing relations. Skilled facilitation by a formal leader not only aids this process but also helps ensure the terms are enacted. Working towards maintaining the health of the partnership and ensuring its work is kept ‘on course’ are other important leadership functions (Engel 1994). However, leadership can also hinder this process, especially when the leaders are nominated by the government, and may even deter some sectors from ‘signing up’. Partnerships based on a ‘top-down’ approach to leadership are

unlikely to engage fully with or adapt to complex and rapidly changing situations. What is important, however, is that ownership of the partnership remains open and equal, whoever fills the leadership role (Cameron and Cranfield 1998). This is particularly important when involving the voluntary sector as they are frequently excluded from key decisions that are often taken within informal, exclusive networks (Taylor 1997). Joint decision-making and shared agenda-setting requires a willingness to share power and responsibilities (Davies and et al. 1993; DoH 1993; Delaney 1994; Taket 1999).

Useful skills or competencies of facilitators and members. The presence of individuals who have vision, desire and commitment as well as the ability to take others with them is considered important in partnership. Powell lists a whole host of useful negotiating and planning skills as well as core attributes (openness, flexibility, vision) and attitudes (positive, constructive and a willingness to listen and learn from others) that can facilitate joint working (Powell 1992). Communication, political and strategic planning skills, as well as the ability of individuals to network, are also considered useful (Delaney 1994; Bloxham 1996; Costongs and Springett 1997). Good channels of communication within the partnership and with the wider community are particularly important for building good relationships (Huxham and Vangen 1996). Partnerships are often concerned with getting their message across but not very good at listening to others. Blocked or ineffective communications can quickly lead to feelings of frustration, anger and a feeling of being excluded. Jargon is a notorious barrier to mutual understanding and dialogue, and can generate or reinforce myths and misunderstandings (Cameron and Cranfield 1998; Taket 1999).

Where there has been a long tradition of local inter-organisational working, people often have the skills, experience, confidence and infrastructure to engage on their own terms and to gear up for new opportunities. However where the history of joint working is potted, the skills for effective personnel and professional relationships between individuals and organisations may be absent and will have to be learnt (Delaney 1994; Bloxham 1996). Developing such 'social capital' in the community and voluntary sector is particularly important, as increasing the level of involvement in agenda-setting and in

the practice of health promotion, will increase the impact on health outcomes (Taylor 1997; Gillies 1998).

Evaluation. Self-evaluation of partnership is part of the learning involved in developing partnership. It can help identify weaknesses in the partnership structures, process, relations and outputs while the act of undertaking a self evaluation can serve to strengthen relations. A number of evaluation tools have been designed for use by partnerships in order to assess their progress. These use various normative frameworks which focus on aspects of partnership interaction, process and outcome that have been identified as facilitators or barriers to partnership in the review of the theoretical and empirical literature (Winer and Ray 1994; Funnell, Oldfield et al. 1995; McCabe 1997; Means, Brenton et al.; Wilson and Charlton 1997).

1.4.3 Other evidence

A number of reviews of health and social care partnership (mainly empirically based) were also identified in the non-UK literature. Mattessich (1992) identified 18 studies of collaboration (as opposed to co-ordination or co-operation) primarily undertaken in the USA but including several UK studies. A meta-analysis of these studies identified 19 influences, similar to those in UK studies:

- Environment (history of collaboration, perception of collaboration as a leader, favourable political/social climate)
- Resources (sufficient resources, skilled convener/facilitator)
- Membership (mutual respect, appropriate member, view collaboration in self interest and ability to compromise)
- Process/structure (members have stake in process and outcome, multiple layers of decision-making, flexibility, development of clear roles and adaptability of group)
- Communication (open and frequent, established informal and formal communications)

- Purpose (concrete goals/objectives, shared vision, unique purpose)

A more recent review of strategic health partnership by Roussos (2000), based on 34 empirical studies (primarily US based) of 252 partnerships, identified similar requirements, including: having a clear vision and mission; action planning for community and system change; developing and supporting leadership (convenor/facilitator); documentation and ongoing feedback on progress (evaluation); technical assistance, training and support for collaboration; securing resources; making outcomes matter (ownership of domain) and to a lesser extent the context of collaboration (history, characteristic of the location etc).

There was also a large literature on private sector partnerships, focusing on the development of strategic alliances and networks or N-form organisations. A comprehensive review of this literature was not undertaken as my main focus was on strategic health partnerships in the public sector. Nevertheless, relevant theoretical literature was drawn upon and incorporated at appropriate points in the thesis.

Some of the issues identified in the empirical literature resonate strongly with aspects of the theoretical perspectives outlined in Section 1.3. For example, recognising and addressing different values and cultures in partnership which could be accommodated in the negotiated order perspective. However, the weakness of the empirical literature is that much of it lacks conceptual clarity. Terms such as trust and power are frequently used without definition or reference to a theoretical perspective. The lack of a theoretical framework gives their findings limited explicative power and over-reliance on platitudes when suggesting remedial action.

Nevertheless, drawn together, the theoretical and empirical literature point to three broad areas that are crucial to the development and functioning of partnership:

1. The national and local context or structure of the environment in which partnership operate

2. The nature and management of interactions between partners
3. The structuring of the content of the decision-making process

The environmental context in which HImP and HAZ partnerships were conceived, created and developed is outlined next.

1.5 The context of health partnership in the UK

This section presents a contextual overview of health partnership in the UK. It begins with a brief overview of health partnership, then presents an outline of the government reforms that spurred HImP and HAZ partnerships and of the philosophical genesis behind New Labour's promotion of partnership. Finally it analyses how these partnerships differed from previous attempts.

1.5.1 A brief history of health partnership

The election of the New Labour government in 1997 marked the beginning of a new wave of reforms to the health service. A central theme running through the reforms was partnership. The White Paper, *The new NHS: Modern, Dependable* (DoH 1997) announced partnership as one of the six guiding principles for the new 'modern' NHS, while the White Paper, *Saving Lives: Our Healthier Nation* (DoH 1999a) reaffirmed the need to work in partnership at all levels of government in order to tackle the public health agenda.

Partnership would lead to a system of 'integrated care', replacing the fragmented service produced by the internal market, break down the 'Berlin walls' that existed between the NHS and social services, and tackle 'wicked' issues such as poor population health in socially deprived communities. The White Papers and key policy documents (DETR 1998) embodied the social model of health, recognising the wider determinants – employment, education, housing and poverty – and emphasising a holistic or 'whole systems' approach to reducing inequalities in health. At the local level, strategic health partnerships would deliver these aims.

The idea of partnership was not new. Partnership, under the guise of co-operation, co-ordination and collaboration, has been a recurring theme in UK health policy for the past three decades, if not longer.

In public health, partnership was a key feature of England's first public health strategy, *Health of the Nation* (DoH 1992). Healthy Alliances were created at a local level as a strategic vehicle for improving health and reducing 'variations' in health. However, the strategy's narrow bio-medical focus and down-playing of the wider determinants of health diminished its appeal, especially in locations where agencies had been engaged in voluntary health partnerships since the mid 1980s through the World Health Organisation's (WHO) Healthy Cities programme or even earlier through its progenitor *Health for All 2000* (Ashton 1992). These partnerships were based on a social model of health and explicitly recognised the need to reduce inequalities in health. However, they did not become strategic partnerships until the Healthy Cities programme moved into its third developmental phase between 1998-2003.

The emphasis on partnership to improve population health has continued. More recent policy documents such as *Tackling Health Inequalities: A Programme for Action* (DoH 2003), the Chief Medical Officer's report on the public health function (DoH 2001a), the second Wanless Report *Securing Good Health for the Whole Population* (Wanless, Jones et al. 2004) and the latest public health strategy, *Choosing Health* (DoH 2004a) all stress this approach.

In health and social care, there have been numerous policy initiatives since the 1960s that have sought to encourage partnership between NHS and LAs, particularly Social Service (SS) departments, at strategic, commissioning and provider levels. Initiatives have included the introduction of Joint Consultative Committees (JCCs) in 1974, Joint Care Planning Teams (JCPT) and Joint Finance (JF) initiatives in 1976 as well as community mental health and learning disability teams (CMHT and CLDT) (Challis, Fuller et al. 1988; Webb 1991; Nocon 1994; Loxley 1997; Robinson and Poxton 1998). There have also been initiatives at a national level to improve co-ordination across

government agencies (i.e. Central Policy Review Staff (CPRS)) (Challis, Fuller et al. 1988).

Since the 1970s, urban regeneration initiatives have adopted a partnership approach to tackling inner city deprivation and poverty – major determinants of health. These have included the Urban Programme, Community Development Programmes and Education Priority Areas (Challis, Fuller et al. 1988, pp.19; Rhodes 1988b, pp.343-366). In the early 1990s, the Conservative government developed City Challenge and the Single Regeneration Budget (SRB). These local regeneration partnerships involved health and LAs and the voluntary and private sector and were based on a social rather than an economic model of regeneration predominant in the 1970s.

Indeed, since its inauguration in 1948 successive reorganisations of the NHS and related services have invariably been justified by the need for improved co-ordination between agencies (Delaney and Moran 1991; Bridgen 2003). However, at a local level, there has been a long and troubled relationship between HAs, LAs and the voluntary sector (Glendinning and Clarke 2000). Despite numerous efforts to encourage partnership, on the whole they have been judged disappointing (Glendinning 2002).

As the literature review suggests, working in partnership is not easy. Barriers to health and social care partnerships *inter alia* include: boundary disputes over organisational responsibility (Audit Commission 1994; Ottewill, Wall et al. 1996), lack of commitment of participating organisations, perverse political incentives (Webb 1991; Nocon 1994), power and informational differentials and clashing professional cultures (Challis 1989; Webb 1991; Pettigrew, Ferlie et al. 1992a). In addition, partnership requires resources and may involve the loss of autonomy or the blurring of organisational boundaries (Davies and et al. 1993). These can be categorised into five barriers: structural, procedural, financial, professional and relational (status and legitimacy) (Hardy cited in Bridgen 2003).

What was the impetus for New Labour to place partnership at the centre of its reforms, given the limited success of previous policy initiatives? This is explored next.

1.5.2 Partnership and the Third Way

A key element behind the Labour Party's electoral success in 1997 was its metamorphosis from old to New Labour. New Labour was shaped by the political philosophy of the Third Way, leading the party to drop many of its more Leftist standpoints, such as Clause 4, which had committed the party to nationalisation. The Third Way was also instrumental in shaping New Labour's policy programme and its platform to modernise the public sector. This section outlines briefly the ideas behind the Third Way before reviewing the reforms to the health service which it inspired.

The Third Way was so called because it formed a new path of political thinking that straddled the 'false dichotomy between the politics of the Left and Right' (Finlayson 1999). Its roots lay in a post-Fordist analysis of society, which saw capitalism in developed countries shifting from large, rigid, industrial-based economies, structured around mass production, to knowledge-based economies founded on flexible, specialised and integrated modes of production (Taket and White 2000a). It coincided with increasing globalisation, the rise of individualism and consumerism, disaffection with distant political institutions and with an increasing recognition of ecological issues. All these trends had fundamental implications for contemporary society, particularly for the role of government and the way that it managed itself and the economy (Giddens 1998). Society was too complex, fluid and diverse to be managed by a central state (Finlayson 1999). In the new circumstances, the government's role was to enable individual empowerment and opportunity and to harness the power of the market to serve the public interest (Finlayson 1999).

The Third Way proposed moving beyond the old centralised command and control systems of the 1970s that stifled innovation and responsibility (DoH 1997). It would also raise the administrative efficiency and transparency of government, restoring its legitimacy. This required more learning from the private sector which, unlike

‘bureaucracy’, was able to respond rapidly to change, using practices such as target controls, effective audit, flexible decision structures and increased participation to reassert its effectiveness (Giddens 1998).

However, state governance was also to draw on civil society and its informal networks and associations (Bennington 2000). New partnerships were to be forged with the voluntary sector and civil society strengthened through active participation, contributing to democratic renewal (Blair 1998; Giddens 1998).

Such reforms were to be accompanied by a strong commitment to social justice, as inequality leads to disaffection and conflict, undermining social cohesion. Inequality was defined in terms of social exclusion – physical exclusion in a spacial sense, and cultural exclusion of certain communities. Government had an active role in addressing inequalities (Giddens 1998), bringing people into the mainstream, enabling them to engage in the knowledge economy, for example (Finlayson 1999), and limiting meritocracy. Conventional poverty programmes needed to be replaced with community-focussed approaches that permitted democratic participation but were also more effective (Giddens 1998).

The Third Way focused on the ends (social justice) rather than the means of delivery, exemplified in New Labour’s dictum, ‘what counts is what works’ (Exworthy, Berney et al. 2002). Instead of stressing bureaucracy over markets or vice versa to deliver a socially just, knowledge-based economy, elements of both were to be harnessed. Key themes in Third Way rhetoric emphasised *community, opportunity, responsibility* and *accountability* (Le Grand 1998; Lowndes and Sullivan 2004; Sullivan, Barnes et al. 2004). Working in partnership was the *modus operandi* for achieving this vision.

Strengthening the range and quality of partnerships would produce public services that were more accountable and transparent, more responsive to consumers’/users’ needs and more innovative in addressing society’s problems (Ferlie, Ashburner et al. 1996).

Public health was one area in which the state, voluntary sector and individuals could work together (Blair 1998). How were these ideas expressed in government reforms?

1.5.3 The Third Way and NHS reforms

‘There will be a ‘Third Way’ of running the NHS – a system based on partnership and driven by performance.’ (DoH 1997, pp.10)

Partnership and performance were two Third Way themes that encapsulated New Labour’s programme to modernise the public sector (Dixon 2001). These were embodied in a number of organisational and structural changes to the NHS and other public bodies. Those relating to strategic health partnerships are outlined below.

Partnership - organisational and structural reforms

Several new partnership structures were encouraged or created at the local level – Health Improvement Programmes (HImPs), Health Action Zones (HAZs) and Primary Care Groups (PCGs).

HImPs were three-year local health strategies which were to be drawn up by health authorities in partnership with NHS Trusts, PCGs, local government, voluntary groups and the private sector to provide strategic direction on how to reduce inequalities, improve health and health care and deliver better integrated, user-centred health and social care. HImPs were to provide an overarching framework for commissioning of local services through Service and Financial Frameworks (SaFFs) and Joint Implementation Plans (JIPs). They were the means of delivering the national targets set out in the *Saving lives: Our Healthier Nation* White Paper (DoH 1999a) as well as locally developed targets and milestones. Guidance on HImPs did not prescribe any structural requirements; it only suggested membership and indicated how HImP strategies should mesh with other planning processes (e.g. SaFFs and JIPs).

Shortly after New Labour was elected, HAs, LAs and other key partners in areas of England with particularly poor health status were encouraged to bid for HAZ status. Successful applications brought additional funds to innovate and ‘freedoms and

flexibilities' to overcome some of the legislative and administrative barriers to joint working so that local inequalities in health and health and social care provision could be redressed. Twenty-six bids were accepted in two waves; the first went 'live' in March 1998, the second in April 1999 (Bauld, Judge et al. 2000). HAZs were underpinned by seven principles: achieving equity, engaging communities, working in partnership, engaging operational staff, using an evidence-based approach, developing a person-centred and whole systems approach (NHS Executive 1999a).

Other area-based initiatives (ABIs) or partnerships were also encouraged in these deprived areas – Employment Action Zones (EAZ) and Education Action Zones (EdAZ). Local regeneration partnerships were set up with health in their remit to spend regeneration monies (New Deal for Communities).

PCGs were partnerships of GP practices (and other primary care professionals) formed to plan and commission healthcare. Three categories of PCG were created, each signalling a different degree of involvement in the commissioning process. Members with more experience and capacity for commissioning, such as those involved in fundholding, were assigned a higher status. A fourth category of Primary Care Trusts (PCTs) would see PCGs become fully-fledged organisations with purchasing and providing responsibilities and financial independence from HAs. The first wave of 17 PCTs became operational in April 2000 (DoH 2000a). Following the publication of *Shifting the Balance of Power* (DoH 2001b), remaining PCGs became PCTs in April 2002 (DoH 2001b). Together these covered most of the roles and functions of HAs, including work on developing and producing Health Improvement and Modernisation Plans (HIMPs) – the successor to HImP strategies (DoH 2001c). HIMPs later transmogrified into Local Strategic Partnership (LSPs). LSPs were created to bring existing and overlapping partnerships and plans into a coherent framework (Social Exclusion Unit 2000).

At the regional level, there was closer working between the NHS Executive and the Social Services Inspectorate, while at the national level, partnership involved 'joined up government' (Exworthy, Berney et al. 2002), with, for example, joint National Priorities

Guidance for health and social care (DoH 1998b) and the establishment of the HAZ and Social Exclusion Units to develop and co-ordinate policy across government departments. A new post of Minister for Public Health, located in the Cabinet Office, was created for this purpose, although this was subsequently down-graded to a Junior Minister role in the DoH.

A duty to work in partnership was also placed on NHS organisations and LAs (DoH 1997), subsequently enacted in the Health Act (1999) and the Local Government Act (2000). The Health Act (1999) (Sections 26-32) also included new ‘freedoms and flexibilities’ aimed at improving partnership working between HAs, PCGs/PCTs and Social Services (SS) departments by ‘removing barriers’ (DoH 1998c). These new measures were:

- Pooled or shared resources with the NHS and other bodies
- Lead commissioners from one organisation to oversee the allocation of pooled funds
- Extension of the scope of services provided by SS and NHS Trusts to allow greater provision of integrated services

Although initially intended for HAZ partnerships, they were later extended to HImP partnerships. Section 32 of the Health Act (1999) also removed the statutory requirement for Joint Consultative Committees (JCCs).

In addition, partnership with the private sector was encouraged to develop new markets for infrastructure investment and service providers. In the NHS acute sector, this was through the Private Finance Initiative (PFI) and, more recently in primary care, Local Improvement Finance Trusts (LIFT).

Performance - organisational and structural reforms

To drive partnership, a range of measures, initiatives and institutions was introduced to monitor delivery and assess performance. In the NHS, *A First Class Service* outlined a three-pronged strategy to achieve this (DoH 1998d): setting clear standards, promoting effective delivery of high quality services locally, and ensuring strong external monitoring mechanisms.

To ensure standards of care and quality of treatment, the government introduced a combination of behavioural and output controls (NHS Executive 1999b). These were set out in the *NHS National Performance Assessment Framework*, and included health service process indicators (i.e. on waiting lists), measures of budgetary management and productivity (i.e. number of hospital admissions) and quality standards. Health outcome targets were also outlined in *Saving Lives* on CHD, cancer, accidents and mental health. Behavioural outputs were set out in National Service Frameworks (NSFs) (Bennington 2000), setting standards of clinical care and service organisation for people with cancer, CHD and mental health and care groups such as older people. In addition, they emphasised working in partnership (DoH 1999b; DoH 2000b; DoH 2001d). By 2001, there were in excess of 400 behaviour and output targets in the NHS, following a stream of policy documents and guidance (DoH 2001e). Following criticisms from the media, MP's and from within the NHS about the distorting impact of so many targets on activity and patient outcome (Gulland 2003; Jackson 2003; Kmietowicz 2003), these were radically reduced in 2003 and a more focused approach to indirect control was introduced. *Delivering the NHS Plan* contained a smaller number of key targets that simply set out the general direction of travel (DoH 2001e; DoH 2002a).

Two new institutions – the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) – were charged with recommending effective treatment and care and monitoring progress in attaining the national targets and standards respectively. Following several mergers, CHI's role was taken over by the Healthcare Commission in March 2004 (DoH 2002a).

The aim of these measures was to facilitate assessment of health improvement, fair access (equity) and effectiveness and efficiency of treatment and care (Dixon 2001). Following the publication of the *NHS Plan* in July 2000 (DoH 2000a), HAs, Trusts and partnerships (i.e. HAZs) were inspected and graded by a traffic light system – red light (failing), amber (borderline) and green (OK). This was later superseded by a three-star rating system. Information collected on performance was used to allocate rewards or apply sanctions. Organisations achieving a green light or three stars were eligible for greater financial and organisational autonomy (i.e. use of the new freedoms and flexibilities). ‘Earned autonomy’ increased access to discretionary resources, resulted in lighter monitoring by the Regional Office and less inspection by CHI (DoH 2000a). Failing organisations were put on ‘probation’, with the spectre of Chief Executive Officer ‘resignations’ and direct intervention for persistent offenders (Shifrin 2002). The ‘carrot’ was somewhat smaller than the ‘stick’ (Watson 1999).

A similar performance management regime was introduced into LAs. ‘Best Value’ required LAs to review all their services over five years, produce a plan that set out local targets and consult the public. Reviews had to assess the competitiveness of services, although competitive tendering (while encouraged) was not obligatory. Performance was to be judged by new audit and inspection arrangements, with the threat of intervention for failing authorities (DETR 1998).

Thus a range of partnerships was introduced to the NHS and local government at the same time as a number of measures to monitor performance. The next section interprets the nature of these reforms, with the aim of identifying the unique characteristics and context of the new strategic health partnerships.

1.5.4 Analysing New Labour’s approach to strategic health partnership

How can New Labour’s local strategic health partnerships be characterised? Huxham’s (1996) schema, presented in Section 1.2, provides a useful framework to deconstruct the government’s model for HImP and HAZ partnerships.

First, as a *mode of organising*, strategic health partnerships were intended to be intensive and mutually beneficial. Located at the centre of decision-making on mainstream activity, their aim was to *improve efficiency* through reducing fragmentation, administration costs (high transaction costs) and bureaucracy caused by the market (DoH 1997; Dixon 2001; Lowndes and Sullivan 2004). For HAZ partnerships, additional funds were available to partners as an incentive.

Second, as a *structural form*, HImP and HAZ partnerships emphasised process (production of HImP strategies, new initiatives etc), not structure. The new freedoms and flexibilities also allowed for greater *integration* of management and finance between organisations (Lowndes and Sullivan 2004).

Table 1.2. The rationale for strategic health partnerships under New Labour

Rationale	Strategic health partnerships	Third Way
Substantive change	<ul style="list-style-type: none"> - Innovative approaches to improving health and reducing inequalities - Improve co-ordination of health and social care - Improve quality and equity of services 	<ul style="list-style-type: none"> - Innovation, providing more flexible and responsive services
Ambitiousness	<ul style="list-style-type: none"> - Share information and knowledge to develop HImP and HAZ strategies - Share financial information to develop SaFFs and JIPs agreements 	<ul style="list-style-type: none"> - Greater efficiency and reduced duplication and sharing of resources
Empowerment and participation	<ul style="list-style-type: none"> - Involve key stakeholders including the voluntary organisations, community groups and the public in decision-making on local policy and resource allocation - Revitalise the democratic process and improving local accountability - Promote use of Compacts 	<ul style="list-style-type: none"> - Democratise and increase accountability
Power relations	<ul style="list-style-type: none"> - Voluntary sector and others to influence local decision-making - Create greater equity in allocation and service provision 	<ul style="list-style-type: none"> - Active civil society influencing decisions
Addressing conflict	<ul style="list-style-type: none"> - Reduce conflict and competition fomented by the internal market 	<ul style="list-style-type: none"> - Social stability and cohesion

Third, the *rationale*, although not explicitly stated, was discernable from policy documents and reforms. Table 1.2 shows how Huxham’s five dimensions of rationale relate to HImP and HAZ partnerships as well as Third Way themes.

How did this compare with the characteristics of previous government initiatives to encourage partnership between health and SS? Since the 1960s, policies have argued that partnership will *improve efficiency* (through rationalisation of resources, reduced duplication and improved co-ordination of policies and services) and increase the *responsiveness* of services (Nocon, Small et al. 1993; Loxley 1997). Early initiatives presumed such reasoning would appeal to the presumed 'rational' and/or 'altruistic' behaviour of public officials and professionals and lead to closer working (Le Grand 1997; Medd 2000). Exhorting the benefits of partnership fell on deaf ears as it did not address more prescient interests of local actors or the social order in which they were embedded. As a consequence, these 'optimistic' and 'naïve' models of partnership failed (Challis, Fuller et al. 1988).

The 1970s saw the advent of structures to encourage partnership (JCCs and JCPT), albeit at the margins of organisations, and the introduction of coterminous boundaries. With Joint Finance being used as an incentive to encourage partnership (Nocon 1994), government policy began to recognise the 'pessimistic' nature of local actors (i.e. as self-interested) (Challis, Fuller et al. 1988). However, structural and professional differences continued to hinder partnership, limiting progress mainly to operational co-operation. This was because initiatives failed to understand the subtleties of power/resource dependency relations between agencies (Webb 1991). In particular, the government failed to ensure domain consensus on the division of responsibilities for health and social care. The structure of payments to move care into the community (out of hospitals) was considered by LAs as biased because it did not recognise sufficiently the shift in costs this entailed (Bridgen 2003). Small budgetary increases and insufficient compensatory payments put increasing pressure on finances and added to ill-feeling. This led to the whole process becoming 'stuck in a rut' (Bridgen 2003). The 1990s saw this model taken to its extreme; with the creation of the internal market, self-interest became the driving force behind social policy co-ordination (Le Grand 1997). This resulted in a greater number of actors and more fragmentation (Ranade and Hudson 2003). Despite the continuing promotion of joint planning and an increase in resource transfer to LAs, there was still confusion over the division of responsibilities,

LA money was not ring-fenced and the role of JCCs and JCPTs was downplayed (Bridgen 2003). Again, the result was a lack of progress.

New Labour had a number of distinctive elements to their programme, compared to previous efforts at local strategic health partnership (see Appendix E on page 386 for a comparison). Partnership was promoted across government as a mainstream issue. Health partnerships were based on a social model of health and a whole systems stance which implicitly recognised the need to involve a wider range of stakeholders in decision-making over local policy and resource allocation. HAZ guidance emphasised the need to manage a network of relations. A new duty was placed on statutory organisations to work in partnership and new powers granted (freedoms and flexibilities) to reduce potential financial and legal barriers. Guidance also helped clarify domains in health and social care, and funds were available to HAZ partnerships as an incentive. New Labour's approach appeared to go some way in addressing some but not all of the failings of previous attempts at partnership.

New Labour's vision was certainly more ambitious than its predecessors. Its rationale for partnerships went beyond the improvement of co-ordination and efficiency which had characterised previous models. Strategic health partnerships were now to develop innovative solutions and tackle intractable social problems such as health inequality. Furthermore, they were also to be a vehicle for empowering citizens, increasing accountability and participatory democracy (Powell and Moon 2001; Sullivan, Barnes et al. 2004). Drawing in the socially excluded from disaffected communities, participation was framed in a consensual way (Hoggett 2003).

The government's model, therefore, encompassed all three notions of partnership outlined earlier in this chapter.

- *Collaboration* – due to its emphasis on innovation, a systems approach and voluntary sector involvement

- *Co-ordination* – due to its emphasis on information and resource-sharing and the efficient organisation of services
- *Participation* – due to its emphasis on the voluntary sector as an influential/equal partner in decision-making on policy and resource allocation

In addition, government reforms emphasised performance to steer partnership and provide performance and financial accountability (Sullivan, Barnes et al. 2004). Although significantly different from previous policy initiatives, this innovation could be interpreted as part of a longer-term trend in public sector reforms in Anglo-Saxon countries. In the UK, these have included the partial privatisation of productive state functions (such as the utilities), the introduction of market mechanisms in the delivery of public services (including the NHS), and the use of private sector management approaches, responding to what was seen as an over-burgeoning and increasingly costly public bureaucracy – a view promulgated by the New Right (Power 1997; Rhodes 2000a). These reforms, collectively termed the New Public Management (NPM) (Ferlie, Ashburner et al. 1996), resulted in the decentralisation, down-sizing and de-layering of government structures throughout the 1980s-1990s, and an ‘explosion’ in the use of regulation, financial and management audit and performance indicators, as a means of ensuring the co-ordination of policy and the accountability of local agencies and the delivery of services (Power 1997). As noted in Section 1.3.1, in the NHS these reforms can be characterised primarily by the development of managed competition and sub-optimisation.

Characteristics of New Labour’s reforms appeared to echo those of NPM. The maintenance of the purchaser-provider split in the NHS, the emphasis on engaging the private sector through PFI, LIFT and contracting out (i.e. in Best Value), the creation of PCGs and PCTs, and more recently the passing of legislation to enable high performing hospitals to become Foundation Trusts, with even greater organisational and financial autonomy, all represented a commitment to the structure of the market and further decentralisation and devolution of management and financial responsibilities (Glendinning and Coleman 2003). Elements of the market mode of co-ordination appeared to be embedded within the reforms.

Similarly, the strong emphasis on indirect control mechanisms to drive performance at a local level, through the creation of new institutions to review evidence and audit and monitor activity, the setting of behavioural and output targets and the use of incentives and sanctions, implied a strengthening of sub-optimisation. Targets represented continuing bureaucratic control, albeit ‘hands off’ in nature (Rhodes 2000b). Indeed, the rapid growth of performance management over the first few years of the reforms, followed by a more focused but equally intense use of this mechanism, indicated that New Labour was strongly wedded to hierarchy as a mode of co-ordination. Nonetheless, the emphasis on partnership, community and active citizenship in New Labour’s reforms signalled either a new development or a challenge to the continuity of NPM (Snape and Taylor 2003).

In sum, the reforms resulted in changes to all three modes of governance outlined in Section 1.3.1 of this chapter. Although partnership moved centre stage in government reforms, it did not replace one or other modes of co-ordination (markets and hierarchy). On the contrary, the other two modes were also extended by government reforms.

It was in this context that New Labour’s strategic health partnerships were established. Closer scrutiny of the Third Way and its reforms reveals a number of inherent contradictions in this model of partnership. These fall out of the tensions between these modes of co-ordination and assumptions on which they and New Labour’s vision for partnership was founded. These are explored next.

1.6 Tensions and assumptions

Following the analysis of New Labour’s strategic health partnership and reforms, and with the theoretical and empirical literature on partnership in mind, three broad themes can be identified which exemplify these contradictions.

1.6.1 Central control, local autonomy conundrum

Strategic health partnerships were set up to act and respond to *local* issues and priorities. A degree of local autonomy was required to allow organisations to be flexible and creative; otherwise participation would be meaningless. While some local priorities could resonate with national ones, inevitably there would be differences. However, despite the rhetoric, government reforms actually strengthened sub-optimisation, increasing hierarchical control over local agencies rather than relinquishing it, through the use of indirect behavioural and output controls. Centrally determined priorities and related performance measures which did not concur with local priorities, therefore, had the potential to constrain a partnership's room for manoeuvre. The fear of failing to meet performance criteria could stifle the risk-taking required for innovation (Bennington 2000). No more so than when the success of new ventures lay outside the control of those instigating them.

The empirical literature indicates that indirect control mechanisms used to co-ordinate policy are influential on health partnership (see Section 1.4). Research on the Health of the Nation strategy, for example, suggested that performance management, if applied appropriately, can be supportive (DoH 1998a), while early research on HAZ partnerships suggests that blunt application of performance management may be detrimental. Were indirect, hierarchical control measures compatible with the formation of innovative local partnerships?

To address this question, the other mechanisms of central government influence need to be understood so that their impact can be untangled. Theoretical and empirical studies point to multiple ways in which central government can influence local partnerships. The focus and coherence of government policy commands, organisational and financial stability and funding streams have all been shown to influence the formation and development of health partnerships, whether through creating resource scarcity, inter-organisational dependencies or creating self-effacement (see Section 1.4). However, these studies rarely distinguish between command and control measures or reveal how the orientation of each may influence the structure, interaction or process of partnership or its outcome.

This thesis explores the tensions created by central command and control mechanisms and their impact on local health partnerships. Drawing on a framework for hierarchy outlined in the section on governance, Chapter 3 charts the nature and influence of central command and central control measures on the formation, processual development and outcomes of HImP and HAZ partnerships. This approach provides a clearer assessment of the impact of indirect control mechanisms on partnership.

1.6.2 Understanding the local dynamics of partnership

The government's reforms developed not only partnership as a mode of co-ordination but also elements of the market. Collaboration between organisations was being encouraged at the same time as competition. Conflicting assumptions were also evident in their approach to collaboration, reflecting different theoretical perspectives in Policy Networks and Collaboration Theory. On the one hand, the government actively promoted a social model of health, a whole systems perspective and network management, emphasising broad stakeholder involvement (critically including the voluntary sector) and innovation. This was redolent of collaboration/network theory, which takes an 'optimistic' view of actors' nature, assuming they would voluntarily engage in partnership for mutual benefit. On the other hand, the government used incentives and sanctions to encourage local partnership, appealing to the self-interested or 'pessimistic' nature of actors to motivate and steer behaviour (Jones, Thomas et al. 2004). It also removed some of the legal barriers between the NHS and LAs to encourage resource exchange. Drawing on the policy networks perspective, actors were assumed to negotiate and bargain over resources, rationally seeking to maximise the utility of exchange through weighing up the costs and benefits.

Thus, local actors were assumed to be both 'knights', acting for the greater good, and 'knaves', acting in self-interest (Le Grand 1997), echoing the *planned bargaining* framework advocated by Challis (1988).

The literature suggests that it is not just the nature of actors that determines behaviour, other factors are important. RDT, for example, identifies two main motivations to get involved in partnership: access to resources and uncertainty. In this model, behaviour and interaction are shaped by how actors interpret their environment. These interpretations are considered to be strongly influenced by actors' ideology or values, such as their professional background and/or organisational culture. This leads them to value the costs and benefits of partnership and define their roles and responsibilities within it (domain) in different ways. Empirical research on partnerships suggests such perceptions are different between medical and local government professionals (Webb 1991) as well as between self-sponsored (voluntary) and employer-sponsored actors (Helling 1998). CT, on the other hand, is less clear about the role of altruism and its impact on partnership. What was the nature of local actors, how did this influence their perception of partnership and their degree of involvement? This question is particularly pertinent for the voluntary sector whose involvement was not mandatory and for whom 'voluntarism' might be expected to be a strong motive (Helling 1998).

Furthermore, the government's approach also saw partnership as a mechanism for increasing local accountability and participatory democracy. This implies that the voluntary sector is able to influence policy development and resource allocation in health partnerships. However, RDT suggests that involvement, behaviour and control over resources in partnership are also influenced by the structure of the macro and meso level environment, whether through the structure of society and the groups and interests it favours or the size and structure of resource dependencies between organisations (Challis, Fuller et al. 1988). Small, resource-dependent organisations, such as those often found in the voluntary sector, might be expected to carry less influence or power over resource decisions than larger organisations with more reliable resource bases (such as health and local authorities). Thus, the government's Third Way rationale for partnership (partnership as *participation*) could easily be undermined by the nature of resource dependency relations. Interaction between large resource-based organisations in symmetrical relations, on the other hand, might be defined by behaviour that does not seek to upset current exchange arrangements, rather than developing innovative activities. Was the government's structuring of resources and changes to the rules of

exchange between health and social care sufficient to accomplish its aim? Such matters were not considered in the government's reforms.

I use RDT in Chapter 4 and 5 as an organising framework to understand what was driving local horizontal relations and the nature of relations in strategic health partnerships. Although this perspective makes assumptions about the nature of actors, it provides a framework to address the issues outlined above.

1.6.3 Managing partnership and assumptions about innovation

Finally, the government reforms assumed that strategic health partnerships would lead not only to better co-ordination between local agencies but also to innovative local solutions to the difficult problems of health inequalities and poor delivery of health and social care (Powell and Moon 2001). HAZ guidance in particular stressed innovation as one of their aims. However, policy documents and guidance did not distinguish between these different types of outcome, nor recognise that the processes to achieve them might be different.

In contrast to the government, theoretical models of partnerships do distinguish between different types of outcome, and suggest fundamentally different processes are occurring. The policy networks perspective sees actors as self-interested and engaged in a process of negotiation and bargaining, as discussed above. Outcomes of this process are described as either zero or positive-sum. The former implies some network members profit at others' expense, due to imbalances in power (asymmetrical resource dependencies), while the latter indicates all parties profit from interaction – it is of mutual benefit. This does not imply that outcomes are innovative. Furthermore, this perspective says little else about the process of interaction or recognise that it can be actively managed.

Collaboration Theory, on the other hand, distinguishes between co-ordination and (radical) innovation and the processes through which these outcomes are achieved. Co-ordination results from the exchange of information and resources. Radical innovation,

however, is assumed to arise through a conflictual process of negotiation, where values and assumptions are challenged and partners come to share a new joint appreciation of the problem and how to address it. Unlike co-ordination, the process results in a reframing of perspectives. To achieve collaboration, process needs to be carefully managed. Crucially it needs to ensure procedural justice – fair, equal and open interaction – otherwise power differentials may undermine the process, leading to the imposition of solutions on partners. Actors involved in collaboration are nevertheless assumed to be altruistic, hold a system-wide perspective and be able to reframe.

I therefore seek to explore how the government's approach to partnership influenced the nature of interaction and outcomes in strategic partnership. Despite appealing to some of the characteristics and assumptions behind Collaboration Theory, was this approach sufficient to result in radical innovation, or were less ambitious outcomes the result? Indeed, New Labour's partnerships, with their emphasis on participation and social inclusion, emphasised consensus rather than conflictual re-negotiation of social relations (Hoggett 2003). Chapter 6 uses Collaboration Theory as a normative framework to explore the nature of interaction in health partnership and the degree of conflict and consensus amongst partners. What type of outcomes were present and how did these relate to the nature of interaction? In this way, the thesis seeks to make an assessment of whether *partnership as co-ordination* or *partnership as collaboration* was achieved, and if so where and how.

The next section takes these themes and issues and turns them into research questions.

1.7 Focus of thesis and research questions

This thesis focuses on two newly created strategic health partnerships, HImPs and HAZs partnerships set up by the New Labour government. Its focus is part exploratory and part evaluatory.

It is exploratory in that it seeks to understand how these strategic health partnerships developed and why, the nature of interaction and how this influenced partnership outcomes. Lack of specific government guidance on the nature and structure of HImPs

and HAZs left considerable scope for interpreting what was meant by partnership, how it should be structured, who should be involved and how.

Three notions of partnership could be identified within the government's model:

- a. Partnership as *co-ordination*
- b. Partnership as *collaboration*
- c. Partnership as *participation*

Although the government's approach to partnership sought to build on the lessons of earlier failed models, it was also accompanied by other measures. These appeared to emulate those of the NPM, most notably the increasing reliance on indirect hierarchical controls such as performance management to steer activity. As a consequence, there were a number of conflicting assumptions and tensions underlying the government's approach, as outlined in the previous section.

The impact of these contradictory elements on the development and functioning of health partnership was likely to be complex and highly differentiated. Understanding the similarities and differences between health partnerships in different local areas was important if the influences and driving forces behind partnership and its outcomes were to be uncovered and understood.

As no comprehensive theory of partnership has been developed, this thesis explores the complexity of this situation by using three relevant theoretical frameworks:

- a. Governance theory
- b. Resource Dependency Theory
- c. Collaboration Theory

These theoretical perspectives operate at different levels of analysis, bridging the gap between the macro, the meso and the micro level as well as between the context, process and outcomes of partnership.

This thesis is also evaluatory. It seeks to assess the government's ambitious aims for partnership, using the notion of partnership as *co-ordination*, *participation* and *collaboration*. Drawing on the findings of the theoretical perspectives, it seeks to identify which of these types of partnership were or were not evident and why, and therefore expose any limitations of the government's approach to creating strategic health partnerships.

1.7.1 Research questions

This thesis seeks to answer the following four research questions:

1. How did the central command and control measures of government influence the development, interaction, process and outcome of health partnership?
2. What factors were perceived to be influential in driving and shaping involvement in local health partnership and what was the nature of horizontal relations?
3. What was the nature of the process in partnership and how did this relate to the outcomes of partnership?
4. Which notions of partnership (co-ordination, participation and collaboration) could be identified in local health partnership and how did these relate to the government's reforms?

The research methods used to address these questions are outlined in more detail in Chapter 2.

Chapter 2 – Research Methods

2.1 Introduction

This chapter outlines the research methodology and methods used in the study, and discusses the advantages and limitations of the study design. It also gives an account of the process and experience of undertaking the research.

The design was developed not only with reference to the type of research questions to be answered but also the type and context of the phenomena of interest – health partnership. Questions were designed to understand the nature of strategic health partnerships and tensions and issues that impacted on their development, and ultimately, their performance. These were outlined at the end of Chapter 1 and, primarily centred on exploring the influence of central government on local relations and partnership development and process, the factors influencing the nature and dynamics of relationships amongst local partners, and the nature and process of interaction and its impact on partnership outcomes. The aim was to use three theoretical perspectives – Governance, Policy Networks/RDT and Collaboration Theory – to explore and better understand the influence of structures, the interactional relationships and processes in partnership, and how these dimensions influenced the output of partnership. Addressing these questions would also allow a broader reflection on the government's policy reforms to the NHS and on how well these appeared to deliver improved policy co-ordination, participation and collaboration around initiatives designed to improve health and reduce health inequalities at the local level. As the study was part exploratory in nature and part confirmatory of theory, it had to be sufficiently flexible in design to accomplish this task. The chapter begins by outlining the approach to studying partnership, then outlines and justifies the methodology used in the study – the different methods used to collect data, the approach to data analysis and the issues faced – before reflecting on the ethics of the study and conclusions.

2.2 Paradigmatic approach to evaluation of partnership

From the discussion so far, it can be seen that partnership is a complex process of social interaction between individuals, organisations and wide structures in society. How individuals and organisations behave will depend on the motivations, perceptions and

understanding of actors within the partnership, the meaning they attach or attribute to others' behaviour and wider views or perceptions in society. The study of inter-organisational relations or partnership can be described as falling into two broad theoretical paradigms or philosophical approaches that underlie the nature of inquiry (outlined below). Each paradigm or approach provides a general way of seeing the world, dictating what kind of scientific work should be done and what kind of theory is acceptable, and what kind of methodology and data collection methods should be used (Abercrombie, Hill et al. 1994).

First, the *positivistic* or *objectivist* approach that is strongly rooted in the modernist perspective of organisations. It advocates that organisational phenomena exist 'out there'. Organisational or decision-making problems, for example, are essentially seen as independent of individual participants' views and beliefs (Rosenhead and Mingers 2001a). Rather, organisations are considered to be an object with dimensions that can be reliably measured by an independent observer (Hatch 1997a). By applying the methodologies framed in the positivist paradigm, researchers attempt to identify how organisational attributes (structure, processes, functions) and the roles of the individual within them are associated with one another or an outcome of interest (i.e. co-ordination). This approach might seek to gain an understanding of the 'law' that operates when considering what types of organisational or inter-organisational structure and function best suit working in partnership, using sophisticated statistical techniques to test theories. One such approach, commonly employed in the study of partnership, is *structural functionalism*. Resource Dependency Theory (RDT) is a good example of structural functionalism. It views partnership as performing a function, an instrument serving an end or purpose i.e. seeking resources for survival and reducing uncertainty. The structure of the organisation and its environment (other organisations) determines the nature of partnership, with little recognition of the role of actors within organisations. Indeed, much research on partnership using RDT uses a positivistic approach, correlating dependent and independent organisational and environmental variables with an outcome (such as a type of partnership structure; a strategic alliance or joint venture). However, it does not seek to study or understand the processes that might connect or influence variables, let alone link them to outcomes. Chapter 1

identifies a number of studies that have taken this approach and the limitations of doing so.

Second is the *interpretative* or *subjectivist* approach to studying partnership. In contrast to the approach above, the interpretative perspective makes no claim about whether or not reality exists independent of the observer; it is assumed that this cannot be known since all knowledge is mediated by experience. Thus, reality is defined by an individual's subjective experience albeit under social and culture influences (Hatch 1997a). Subjective experience is at least as important as any objective measure of joint working since it is the subjective impression that influences the behaviour of the individual in collaborative working (Costongs and Springett 1997). This approach is closely allied with the symbolic-interpretative perspective of organisations. It views life as an unfolding process in which individuals interpret their environment and act on the basis of that interpretation (Bryman 1988, pp.54). Bulmer identifies three premises of symbolic interactionism, whereby individuals act on the basis of meaning; meaning comes from social interaction; and meaning is handled through interpretative processes by individuals (Bulmer 1969). Analysis from this perspective begins from the point of view of the actor, that is the understanding that a participant in a social situation is aware of what the situation is and what their place is within it (Cuff, Sharrock et al. 1990, pp.142). Interaction is then seen to entail a continual process of mutual interpretation of the situation by actors and how they believe they will be received (Bryman 1988). Actors are constantly in a process of 'negotiation' with one another as they reaffirm, revise and replace the social arrangements under which they act together (Cuff, Sharrock et al. 1990). Thus, studies which take an interpretative perspective examine the acts, activities, meaning, modes of participation, relationships and setting of inter-organisational activity (Molnar 1984). They attempt to discover, explore and convey the social-psychological paradigms that govern perceptions, conduct and reaction in inter-organisational settings (Molnar 1984). The emphasis is on qualitative data collection methods (rather than quantitative methods preferred by positivists) such as unstructured or semi-structured interviews, participant observation, focus groups and documents etc, which can reveal the interpretation, motivations, understanding and meaning held by actors.

An example of symbolic interactionism is Negotiated Order Theory (Strauss, Schatzman et al. 1963; Cuff, Sharrock et al. 1990). This provides the foundation for Collaboration Theory (Gray 1989), the third theoretical perspective on partnership, outlined in Chapter 1. In this view, partnership is similarly construed as an interactive process, where actors in a perpetual process negotiate the rules of engagement and exchange. An individual's interpretation of a partnership or the behaviour of others within it is considered to have a crucial bearing on how a partnership functions or develops. Although it recognises actors as located within various structural and organisational confines, this influence is secondary to the negotiation process.

As this study was partly exploratory and sought to address research questions about complex issues concerning the nature of interaction, process and development of partnership, an interpretative study design was considered more appropriate. Such an approach enabled a better understanding of the motivation and behaviour of individuals in partnership and the meaning attributed to their and others' action. Understanding context of action and behaviour is important.

It could also accommodate the three theoretical perspectives outlined in Chapter 1, even RDT (which for the most part has been developed using a positivistic approach). In a positivistic sense, an interpretative approach could help fill in the gaps between correlated variables such as organisational attributes and outcomes. Understanding the behaviour and influences on individuals in partnership enables a more realistic extrapolation of the findings of health policy than those of correlated variables.

The theoretical paradigm underlying the study has major implications for research design and data collection methods, as already noted, with the interpretative approach generally placing greater emphasis on observational methodologies and qualitative data collection methods.

2.2.1 Methodological approach to evaluating partnership

As is evident from the discussion so far, partnership is a dynamic, evolving and ephemeral organisation form. This study attempts to capture and understand the

complex nature of relations and their drivers and the process of partnership, the interplay of actions, reactions and interactions over time. However, these processes do not occur in a vacuum but are influenced and shaped by the *context* in which they occur and their *content*. It is useful to distinguish between *outer* and *inner* contexts, outer referring to national economic, political and social context and inner to the ongoing strategy, structure, culture, management and political process of each district (Pettigrew 1997). The content may be *radical*, *incremental* or *technological* (Pettigrew, Ferlie et al. 1992b). The content of HAZ and HImP partnerships was health improvement and reducing health inequalities, arguably both radical and incremental. The approach of focusing on context, process, content of changing organisations is called 'contextualism' (Pettigrew 1985) and has been used not only to evaluate health services but also healthy alliances (Pettigrew, Ferlie et al. 1992a; Fulop, Elston et al. 2000). More recently Pawson (1997) has argued for a greater understanding of causality in health and social change processes, proposing an approach called 'realistic evaluation'. This specifically tries to understand how *Context* (C) influences *Mechanisms* (M) (i.e. social programmes with their new ideas, resources, ways of working etc) to produce specific *Outcomes* (O) (i.e. a change in behaviour). Outcomes, therefore, are explained by the action of a particular mechanism in a particular context in what are called C-M-O configurations. Given there are many contexts (C₁, C₂, C₃...), mechanisms (M₁, M₂, M₃...) and outcomes (O₁, O₂, O₃...), the crucial point is to identify and articulate possible C-M-O combinations (i.e. C_x-M_y-O_z), using theory and empirical evidence, and then to test and refine them. A number of studies have used this approach in the evaluation of partnership, including the national evaluation of HAZ partnerships (Evans and Killoran 2000; Judge 2000) although not without difficulties (Sullivan, Barnes et al. 2002; Cole 2003). Others have used the ideas of context, process and outcomes (including inputs and impacts) to form a framework to evaluate HAZ partnerships (Asthana, Richardson et al. 2002). In order to reach a satisfactory understanding of the development and functioning of health partnership, this study paid close attention to the context, process and outcome of partnerships in order to identify causal links. The analysis led to the development of the framework in Figure 2.1 for evaluating partnership, and shows the theoretical frameworks which best explain causal links across the many C-M-O configurations in sites. The use of theory is important; otherwise slight but unique variations in context and mechanism may result in an infinite number of C-M-O configurations. The framework in Figure 2.1 draws on the

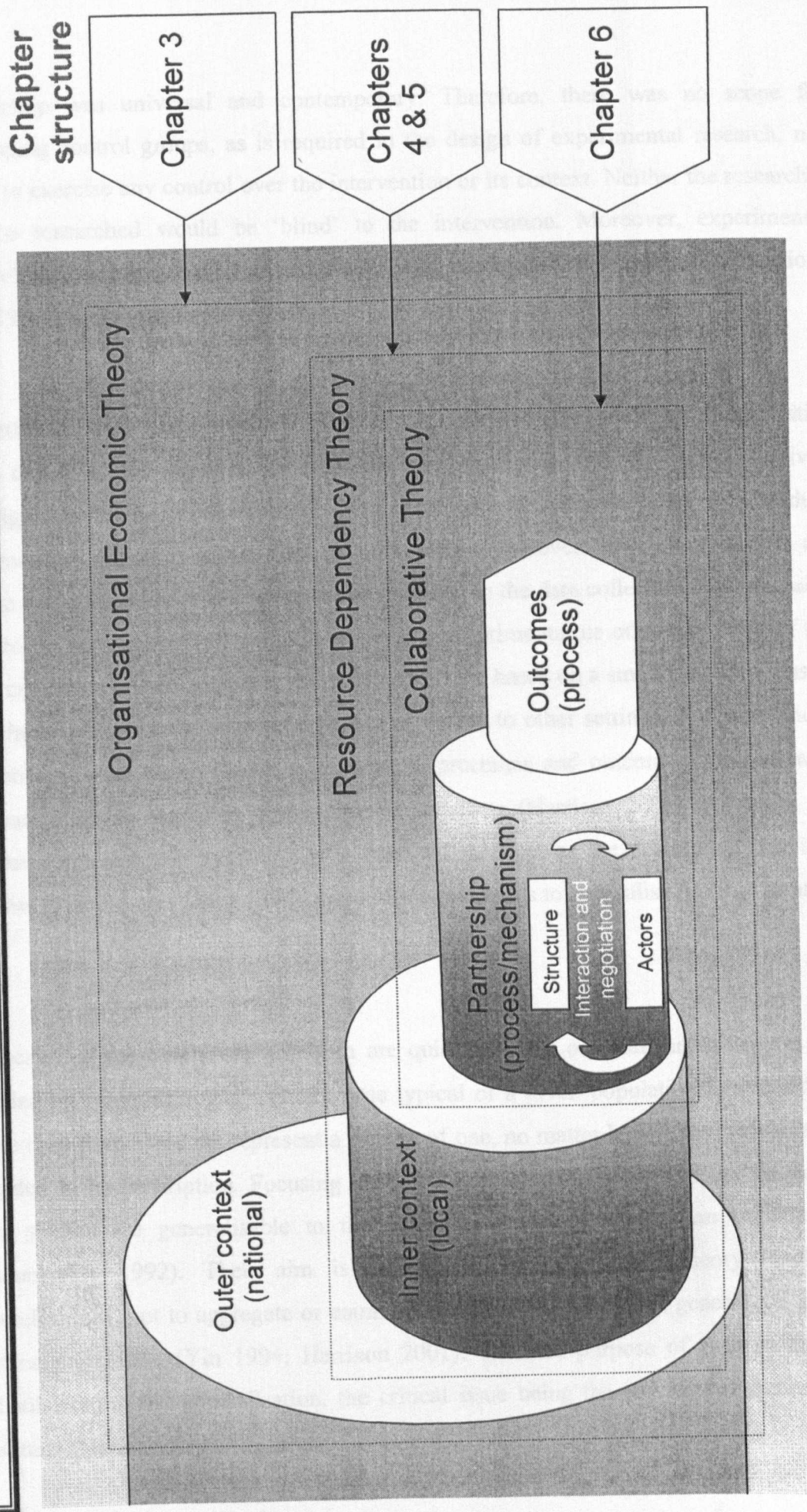
three theoretical perspectives outlined in Chapter 1. As each theory is based on different assumptions and tends to focus on different elements of the casual links in the C-M-O configurations i.e. C-M or M-O, the framework provides a useful way to understand the nature and development of partnership and how this relates to different outcomes. Figure 2.1 also shows how the framework relates to the structure of the thesis.

2.3 Research design – case study

A case study research strategy was selected as the most useful approach to investigating health partnerships, given the range of issues to be investigated and the complex ways in which the concepts related to one another.

A case study approach is particularly suited to evaluating organisations, roles, interaction and events, when involving many actors. The strategy is particularly useful for evaluating complex, real life interventions (such as organisational processes)(Keen and Packwood 1995). It can provide a richly detailed ‘portrait’ of a particular social phenomenon, capturing the different interpretations of events espoused by different interest groups. An investigation to explore the issues and concepts outlined in Chapter 1 required a close and detailed study of a variety of aspects of partnership, such as those relating to how organisations and individuals interact with one another, the influences or constraints structures and environmental context place on their behaviour and relationships, and the impact on the process of partnership development. The health partnerships under investigation were still in the developmental stage at the time of the study and the partnership agenda was still being implemented. For example, a number of legislative measures and government proposals aimed at improving partnership were out for consultation or being considered for parliamentary approval when the study began (DoH 1997; DoH 1998b; DoH 1998c; DoH 1999a). A case study strategy was able to cope with the distinctive, evolving situation in which health partnerships were developing and in which there were many more variables of interest than data points (Allen 2000). An experimental research design was rejected, as it was not considered feasible or desirable. As noted already, the policy to introduce health

Figure 2.1. Analytical and theoretical framework of thesis



partnership was universal and contemporary. Therefore, there was no scope for developing control groups, as is required in the design of experimental research, nor scope to exercise any control over the intervention or its context. Neither the researcher nor the researched would be 'blind' to the intervention. Moreover, experimental research is generally not well suited to addressing exploratory (how and why) questions (Yin 1994), as was required by the study.

Nevertheless, there are a number of criticisms of the case study strategy. Some critics argue that it is less rigorous when compared to strategies that employ the positivist paradigm, as it does not provide experimental controls. Biased views may unduly influence the direction of the findings (Yin 1994). However, such a criticism is not unique to case studies. It is a problem that is linked to the data collection methods used, a problem which besets all research strategies, experimental or otherwise. One of the main criticisms of case studies is that the findings are based on a small number of cases; thus there is little basis for generalising their results to other settings. A conscientious collection of data about the case, its context, processes and outcomes, together with adequate analysis may allay some of these concerns (Harrison 2001). However, the 'representativeness' or 'typicality of a case will get lost as the descriptive baselines increase (Pawson and Tilley 1997), undermining attempts to generalise findings to other sites.

Advocates of the case study approach are quick to point out that the strategy is not founded on sampling logic, where a case typical of a given population is selected. A single case study does not represent a sample of one, no matter how many variables are recorded in its description. Focusing on the lack of generalisability misses the point. Case studies are generalisable to theoretical propositions rather than populations (Hammersley 1992). Their aim is to develop and generalise theory (analytic generalisation), not to aggregate or enumerate frequencies (statistical generalisation) in a given population (Yin 1994; Harrison 2001). The real purpose of case studies is particularisation not generalisation, the critical issue being the cogency of theoretical reasoning (Hammersley 1992; Stake 2000).

2.3.1 Type of case study – multiple

The study used an embedded multi-case study design (Yin 1994). This was considered to be an appropriate design as the study was not testing a well-formulated theory on a unique, critical or previously inaccessible case (HImPs were new, universal partnerships). Multiple cases allow theoretical propositions to be tested across sites and greater refinement of analytic generalisations. Replication of similar predictions in two or more study sites adds confidence to the findings, strengthening their precision, validity and stability (Miles and Huberman 1994; Keen and Packwood 1995), making the evidence more compelling and the overall study more robust (Yin 1994; Ferlie 2001). A multiple case study of four sites was appropriate for this study, given the human and financial resources available and the timescale. This provided a balance between understanding the case studies in sufficient detail to allow the application of theoretical perspectives together with enough case variety to test out theoretical propositions in different contexts and identify any replication on which to make analytical generalisations. This was considered important as the study was also seeking to use its findings to address policy implications.

2.3.2 Unit of analysis

The unit of analysis for the study was the local health authority area, as HImP partnerships were set up with these as their boundaries. The HImP and HAZ health partnerships were the main sub-units of analysis, although the intersection and interaction with other strategic health partnerships such as Healthy City and SRB partnerships were also of interest. Fifty randomly selected health authority areas (of the 99 in England) formed the population from which the study sites were drawn. A documentary analysis of HImP strategies from these 50 sites was undertaken prior to the case study research in order to provide contextual information about the development of local partnerships (see Section 2.6). Four study sites were then identified from this population using the selection criteria outlined below.

2.3.3 Study sites and selection criteria

The process of selecting sites is central to the case study approach. As noted above, the case study approach is not based on sampling logic. Study sites do not necessarily have to be representative of the population under study. Given that the policy intervention being evaluated was universally implemented, selection could only focus on different contexts of implementation. However, there was little reason to structure comparison of

sites around factors for which there is neither existing evidence nor plausible *a priori* reasoning concerning an effect on the impact of the policy (Harrison 2001). Sites should be selected using criteria that are able to confirm or refute a hypothesis (Keen and Packwood 1995).

Two criteria were used to select potential study sites. Empirical evidence outlined in Chapter 1 suggested that they might have a strong bearing on how partnerships would develop. They were also relevant to the research questions (Miles and Huberman 1994).

The first criterion related to presence or absence of a HAZ and the second to location – urban or rural. Unlike HImPs, which were mandatory partnerships for statutory organisations, HAZs were voluntary partnerships funded through a bidding process, and granted to authorities where there was a strong history of joint working. Selection on HAZ criteria gave a unique opportunity to assess the influence of short-term, additional monies, ‘flexibilities’ and of the kudos attached to HAZ status on the development of the HImPs, and partnership relations in general.

Figure 2.2. Case study selection matrix – urban and rural by types of health partnership

Type of site	HAZ present	HAZ not present
Urban	Metrocity HImP, HAZ, HC/HFA (plus others partnerships*)	Middleton HImP (plus other partnerships*)
Mixed urban /rural, Rural	Dalesville HImP, HAZ, HC/HFA (plus others partnerships*)	Greenshire HImP (plus other partnerships*)

* These include JCCs, SRBs and City and Region-wide partnerships

The second criterion enabled me to draw comparisons between very different geographical areas, with different local authority structures, political allegiances and health problems. Rural areas were also potentially presented with a number of practical difficulties around meeting and/or involving the public, because of the larger distances involved and the number of organisations. These two criteria were combined to form a 2x2 matrix (see Figure 2.2) and used to select four sites from 99 health authorities in

England. Identification of rural areas was made using the ONS area classification code for health authorities (DoH 1996) and a map of the NHS in England. This led to an inclusion of sites in the rural category that were mixed urban-rural, due to a lack of appropriate sites (HAZs were mainly situated in urban areas).

2.3.4 Selection of study sites and access

Case study sites fulfilling the selection criteria were identified and allocated to a section of the matrix. A case was randomly selected from each section of the matrix and a letter sent to the Chief Executive Office (CEO) of the Health Authority explaining the study and inviting the organisation to participate. It also assured confidentiality of interviewees and sites. Three health authorities declined, prompting a subsequent random selection of sites and further letters of invitation. Reasons for declining included lack of time due to the large change agenda, the presence of other researchers at the site and an impending local crisis.

Since full participation and co-operation of the local authority was also essential to the study, letters of invitation were also sent to the CEO of the local authority(ies) within the consenting health authority sites. All local authorities in the study sites agreed to participate in the research. In addition, before commencing research within each study site, assurance was sought from the person responsible for co-ordinating the HImP (and/or the HAZ) that all members of the health partnerships were aware of the study, understood what it was about and were happy to participate. Specific letters of invitation were also sent to stakeholders when identified as important, or to key participants in local partnerships. Overall, seeking consent was a lengthy process, taking over four months to identify and recruit four sites and notify respective stakeholders. The aim was to ensure that participants were aware of the research, understood its purpose, were reassured about confidentiality, and had given written or verbal consent to take part. The purpose was to reduce any untoward fears or anxieties that participants might have had about the research and, in so doing, reduce the risk of behavioural change, a phenomenon frequently referred to as the Hawthorne effect (Haralambos and Holborn 1990b, pp.705).

2.3.5 Brief description of site selected

A brief description of the case study sites is given below. Pseudonyms have been used to ensure that the location of sites remains confidential, a commitment given to all consenting organisations. These were chosen to facilitate memory of the type of site.

Middleton is a small city with a coterminous unitary local authority. It is a fairly poor city due to the collapse of its manufacturing base during the 1980s and early 1990s. It has a moderate ethnic minority population living predominantly in a few inner city areas. The city has a history of partnership working and has developed a city plan with input from the statutory, non-statutory and private sectors in response to its industrial decline. When this study was undertaken, it was served by one large acute trust, one community trust and three PCGs. There had been a recent change in the political party governing the local authority, from Labour to Liberal Democrat.

Greenshire is a large rural area with a few small urban centres. It is coterminous with the county council and contains a large number of district/borough authorities. It has a mix of areas of affluence and small pockets of deprivation. There is a low ethnic minority population. At the time of the study, it was served by six NHS trusts (including acute, community and mental) and seven PCGs. It had a moderately good history of joint working but the HFA 2000 partnership was disbanded with the establishment of the HImP partnership. The political party in control of the district authorities at the time was Conservative, although in some districts the Liberal Democrats had recently held sway. In the main urban centre, the Liberal Democrats were in power.

Metrocity is a deprived inner city area with a large ethnic minority. When the study was undertaken it was coterminous with two unitary authorities, one of which had recently changed political leadership to Liberal Democrat while the other remained in control of the Labour Party. It was served by at least three acute trusts and one community and mental health trust and four PCGs. There was a history of joint working indicated by the presence of a Healthy City and HFA 2000 partnerships.⁴

⁴The granting of Healthy City status requires local organisations to demonstrate strong partnership working.

Dalesville is a mixed urban and rural area. It contains a small number of district councils but is not coterminous with the county council. In urban centres, these were in the control of the Labour Party, while in more rural areas the Conservative Party held sway. It is a moderately deprived area, whose industrial base has dwindled over the past three decades, leaving just a few areas of affluence. It is predominantly white working class, with a small ethnic minority population below the national average. It was served by two NHS trusts and five PCGs. It has a mixed history of joint working but despite these difficulties has established Healthy City and HFA 2000 projects.

A demographic profile of each study site is presented in Appendix F on page 387.

2.3.6 Data collection period

Data was collected between January and December 2000. A small number of interviews were undertaken in each site over the first two months. These were mainly with the HImP co-ordinator but also included HAZ and HC co-ordinators. The aim was to establish contact with the sites and gain a preliminary understanding of the state of development of the local HImP. The timetable for meetings and contact lists for local HImP and HAZ partnerships were sought as well as relevant documentation. The most intense period of data collection was from May to November 2000. Since different sites were at different development stages, collection was not evenly spread between sites over this period. The majority of interviews in each site were conducted over a two-month period while observation work continued over a more prolonged period. During the study period the government continued to develop policy in the area, for example, the NHS plan which was published in June 2000, and the impact of these policies was also monitored (DoH 2000a). In addition to the collection of data in study sites, I attended two meetings at the Health Development Agency, London, to discuss HImP development and progress in England. These provided a useful source of additional material as representatives from local, regional and national offices of the NHS attended. It also gave me an opportunity to sound out ideas and corroborate emerging research findings with attendees from other health districts. Although data was collected throughout the year, within sites it was collected in small bursts. Data collection in each site, therefore, represented a slice of time. This enabled me to capture responses to the changing policy environment and developments in the partnership structure.

2.3.7 Data collection methods

Selection of appropriate data collection methods and management of collected data are crucial to the case study strategy. Yin (1994, pp.94) argues for the need to use multiple sources of evidence to develop converging lines of inquiry. Data sources can be from both qualitative and quantitative collection methods (Keen and Packwood 1995). Use of a variety of data sources can also help with concerns over validity (construct, internal and external) and reliability of the findings of case studies, as data can be triangulated (Miles and Huberman 1994, pp.266; Yin 1994, pp.94). Ultimately, the selection of data collection methods depends on the objective(s) of the study, and which methods are best suited to elucidating the issues under investigation. This study drew on three sources of data: interviews, direct observation and documentary evidence. This combination was thought necessary to understand the nature and dynamics of partnership and their impact on partnership and policy development. These methods and how they were used are discussed in more detail below.

2.4 Interviews

Working in partnership is about the action and interaction of people. In order to understand why people act as they do, it is important to understand the meaning and significance they give to their actions (Jones 1985). Interviewing is one way of accessing an individual's motivations and perceptions, yielding rich insights into people's experience, opinions, attitudes and feelings (May 1997) and their interpretation of events and actions (Fontana and Frey 1998). Interviews were used to collect the perceptions of actors as to how the partnership was developing, the nature of relationships, the influences affecting the partnership and the development of local health policy. These formed the primary source of data for the case study.

The interview format was semi-structured. This was preferred to in-depth interviews as a high degree of structure provides for easier cross-case comparison of responses in the analysis (Miles and Huberman 1994; May 1997). The semi-structured format enables interviewees to elaborate on answers while also allowing the interviewer to clarify responses and to probe where answers are superficial. Thus, the semi-structured interview allows the researcher to enter into a dialogue with the interviewee (May

1997), giving scope to pursue issues which were of concern for the interviewee as well as for the researcher.

The interview schedule used pre-established categories of questions to guide and focus data collection, ensuring all aspects of the complex behaviour and interaction of individuals in health partnership, outlined in my literature review, were discussed. Questions were also open-ended. This enabled respondents to answer at length and in their own words. It also avoided the need to choose their response from an *a priori* codified category, which could have limited the field of inquiry (Fontana and Frey 1998). Using a semi-structured interview enabled the time available for interview to be managed to its full potential. This was important as many of the interviewees were senior officers with little time to spare. The interview schedule is included in Appendix G. Its contents were adjusted slightly according to the respondent's sector.

2.4.1 Developing the interview schedule

The content of the interview schedule was developed from the issues identified as influential in the theoretical and empirical literature outlined in Chapter 1. Questions were devised to explore these issues. These were grouped into four theme areas, focusing on the structure (structure) and development of the partnership (process), the nature of relationships (interaction) and process of policy development and implementation (policy). This provided the basic template for all semi-structured interviews, and was used to develop fuller, more detailed interview schedules for the different categories of organisation/sector and type of respondent in the study (see section below on the sample frame for more details). On the whole, schedules were fairly similar in content, varying slightly in length and emphasis, depending on the respondent. For example, questions to the statutory agencies relating to the role of central government were worded differently to the questions in the voluntary sector interview schedule, as the latter had no formal relationship with central government.

The basic interview schedule was piloted and refined during the first five interviews. This involved identifying questions that were misinterpreted or that resulted in a confused or questioning response. Modifications were then made to clarify words or

meaning. Given that some of the issues under study were quite abstract, such as power dependency relationships in the partnership, formulating questions to elicit empirical discussion of these research topics required careful crafting (Kaufman 1994). A series of questions was therefore developed around the hypothesised practical manifestations of these conceptual issues. However, a balance was kept between pre-structuring the direction of the enquiry and giving time and space for the respondents to emphasise and elaborate on their own views on the topic (Jones 1985) in their own terms and frames of reference (May 1997). The length of the schedule was also adjusted so that the interview could be conducted within an hour. For the few interviewees that could not commit to an hour, a more flexible approach was taken. A short interview guide outlining the key areas of inquiry was used as a prompt sheet to direct questions.

The wording of questions was kept simple and straightforward. On a number of occasions, the interview schedule was modified or supplemented with questions to accommodate issues or context that had arisen out of what previous interviewees had revealed to me. Discretion was crucial here in order to ensure any comments or inside information could not be directly attributable to another interviewee. In several interviews, the interviewee clearly had an agenda or issues they wanted to vent, such as the conduct and influence of a particular person in a partnership. On these occasions the issue was pursued until all relevant aspects had been examined. The interview was then steered back towards my interview brief, foregoing any issues that had already been covered.

2.4.2 Sample frame

The study population consisted of those people who were involved in strategic health partnerships in each locality. The main focus was on members of the HImP but it also included members of HAZ, Healthy Cities, HFA 2000, SRB partnerships and Chief Executive groups, particularly those individuals who were members of more than one strategic partnership. The study population also included individuals who had been actively involved in these partnerships but were no longer members or were lapsed members. This ensured access to individuals who potentially had particular knowledge or a view on the manner or conduct of the partnership and its historical development that may have been different to that of its current members, i.e. they may have been

dropped or sidelined from the partnership and therefore had a different view or story to tell.

2.4.3 Sample selection

In qualitative research, sampling strategies are determined by the purpose of the research project and not by statistical representativeness (Britten 1995). The aim of the research was not only to capture a broad range of opinions and perspectives about how the partnerships functioned but also to know how each participating organisation viewed the partnership and its role in the development and implementation of health strategy. Potential candidates for interviews were identified by key informants in each locale (such as a HImP or HAZ Co-ordinators). Partnership membership lists and the 'snowballing technique' – where informants are asked to nominate other key stakeholders for the study, and nominees subsequently asked to nominate others until no new names arise – were also used (Scott 1991; May 1997). This helped identify individuals besides those identified by partnership co-ordinators, particularly those individuals no longer participating in the partnership. Individuals who were members of more than one partnership were considered particularly important to interview as they could reflect on their comparative experiences. This selection approach was combined with purposive sampling – selecting informants for known characteristics (May 1997) such as level of seniority (senior and operational staff) and organisational sector/type. This ensured that a balanced cross section of health partnership membership was represented in the interviews, not overly biased in one direction. Appendix H on page 394 shows the different categories and numbers of interviewees in each study site.

2.4.4 Sample size

In qualitative research, sample size is not determined by hard and fast statistical rules but by other factors (Britten 1995). These relate to practicalities surrounding the conduct of interviews as well as the content of respondents' answers. A balance was struck between what was feasible for a single researcher to undertake within a limited research budget and timeframe and the objectives of the study. Thus, the number of case study sites, the number of individuals and agencies involved in the HImP/HAZ partnerships and the depth and duration of interviews were counterpoised with the collection of data sufficient to ensure that a good, broad-based knowledge and understanding of the issues affecting the development of the HImP (and/or HAZ)

partnerships in each site could be made. One way of making this assessment is to use the strategy of 'sampling to redundancy'. Interviews were undertaken until no new perspectives or issues emerged from the data. Given that the HIMP/HAZ structures were very large in all case study sites, this happened after about 20 interviews.

2.4.5 Conducting the interview

The study used the face-to-face, individual interview. Potential interviewees identified through the selection process above were contacted by letter or telephone (where previous contact had been established i.e. at the observation of a partnership meeting) to request an interview. Interviewees were assured confidentiality, and that all quotes and site locations would be anonymous so as to render attribution of comments impossible (Fontana and Frey 1998). All those individuals contacted agreed to an interview, although on two occasions the practicalities of arranging a suitable time for interview precluded the conduct of an interview within the data collection period. People were interviewed in private in their place of work. Permission to record interviews was also sought in the introductory letter and again before the interview commenced. Interviews were tape recorded and transcribed as soon as possible after the event. In one interview, the tape machine failed and written notes were taken. These were transcribed and written up immediately after the interview. Additional field notes were made directly after interviews about my thoughts and impressions of how the interview process had gone and on interviewees and their answers (see Field notes in Section 2.5). For example, comments were recorded on the context of the interview, on any non-verbal communication that had taken place during the interview (Fontana and Frey 1998), and my feeling about the genuineness of responses as well as any other relevant observations. On several occasions informal conversations were held after the formal interview had finished. These discussions, committed to memory, were written up as soon as was practically possible.

In total, 81 interviews were conducted. The majority of these were between 45-70 minutes in length. On several occasions interviews had to be shortened due to unforeseen circumstances. This was usually made explicit at the start of the interview and the interview schedule was adjusted accordingly.

Transcription was undertaken by an employee of the university on the proviso of absolute confidentiality of the material being transcribed. Where comments or statements in the transcription did not make sense, the original recording was referred to in order to clarify matters.

2.4.6 Analysis of interviews

Transcripts of interviews were analysed with the aid of NUD*IST 4, a qualitative computer software programme (Richards and Richards 1998a). This software programme can be used to discover and manage unrecognised ideas and concepts and to construct and explore explanatory links between data and emergent ideas (Richards and Richards 1998b). It can also enhance the validity of research (Silverman 1998). Interviewee, partnership, organisation and case study site details, together with date and time were added to each transcript to facilitate identification and comparison. Interview transcripts were read through carefully and coded broadly as to whether the material related to the structure of partnership, the process of partnership development, the interaction of individuals and policy development. The material was further coded using categories developed on themes and issues arising from the theoretical frameworks identified in Chapter 1 and the empirical literature. Additional categories were also created for other themes or issues that emerged or reoccurred in the data. Thus, transcripts became layered in codes. Coding was generally linked to several paragraphs of text rather than to sentences to ensure the issue coded was in context. Many pieces of text referred to several themes or issues and therefore contained multiple codes. Initially many codes were *descriptive* with some *interpretive* codes identifying motives and behaviours. As analysis progressed, and with greater familiarisation with the data, *pattern* codes were also developed (Miles and Huberman 1994). These highlighted emergent patterns in local events and relationships. Some codes also became redundant. Textual material assigned to a code was printed off and was analysed closely, looking for common themes, patterns and causal links. These were condensed down into note form and grouped together. Similarities and discrepancies between study sites, type of organisation and interviewee were investigated. Coded themes, issues and interaction were then written up in a narrative form and interpreted where possible, using the theoretical frameworks. This led to further refinement codes and some recoding. Codes which contained the most material and which were considered a significant issue by

informants were prioritised. Theoretical reflection on the outcomes of this writing process led to further links, commonalities and patterns being identified. The results were further refined and reframed, using the theoretical perspective outlined in Chapter 1. These were written up and formed the basis of findings in Chapters 3, 4, 5 and 6.

In qualitative research, analysis is an iterative process whereby the researcher is in a continuous process of referring to the data and refining codes and reflecting on theory. It is a cyclical rather than a linear process, with the research moving to a higher level of abstraction through each cycle (Martin and Turner 1986) as insight is generated and findings emerge. This was the experience in this study, with the interview material being coded and interpreted through three iterative rounds.

2.4.7 Comment on interviews

Relying on interviews as the sole source of data collection may produce biased results, as interviewees might have wanted to present themselves in a good light, had poor or selective recall (especially on matters they are unwilling or perhaps unable to talk about), or been constrained or influenced by the role they occupy (Becker and Geer 1972; Mays and Pope 1995). However, in only a handful of interviews was there a feeling that the interviewees were not being frank or sincere, or that they were being disingenuous. Although there were one or two interviews where there was a sense that the interviewee had a desire to gauge what was said by what they thought the researcher wanted to hear, there were many more interviews in which it was felt that the interviewees were being candid. For example, in the middle of a number of interviews, respondents frequently double-checked about confidentiality before making a particular comment, indicating a willingness to be open. This also re-emphasised the importance of assuring confidentiality to participants. To help minimise such sources of bias, the study sought to corroborate an interviewee's perception of events with other sources of data besides that collected in other interviews. This is discussed next.

2.5 Observational methods

Observational methods can help to circumvent the bias inherent in the accounts people give of their actions by observing them in context. This allows the researcher to identify

any discrepancies between what people say and what they actually do (Mays and Pope 1995). These are particularly well suited to the study of people in organisations, their work and function. As a method, it has the advantage of uncovering behaviours or routines of which the participants themselves may be unaware (Mays and Pope 1995). Observational methods can also give useful insight into concepts such as organisational culture, shared norms, values and symbols (Crompton and Jones 1988). They can also enhance crosschecking or triangulation against data gathered by other means (Alder and Alder 1998). For all these reasons, this study used qualitative observational methods.

A key issue in qualitative observation is the degree to which the researcher engages with those being observed (Alder and Alder 1998). The balance between observation and participation depends on the aims and history of the research, the kind of data sought and the time available to undertake research (May 1997). This study was interested in the process of interaction between individuals from different organisations and how behaviour, assumptions and values of those involved in partnership influence its work on health strategy. Observing as a participant would have given me a valuable insight to the nature of these informal relations and the 'working' of partnership in each study site. However, using this approach can make it considerably more difficult to negotiate access to sites (Alder and Alder 1998). The observation work itself would also have been very time consuming to undertake (especially if the presence of the researcher was to be normalised to such an extent that the Hawthorne effect was negligible – another benefit of this method). A further argument against collecting observational data as a participant was that the interaction and input of the researcher may have changed the nature of the very relationships under study. Given these difficulties, a non-participant approach to observation was preferred. As the human resources available for the study were limited, the observational work mainly centred on partnership meetings. These were the main forums in which partners met regularly. Formal HImP and HAZ meetings took place once every two to three months (depending on the site) and provided an excellent opportunity to observe behaviours and the dynamic of relations in a less obtrusive manner. This was supplemented by observation of several partnership development days at some of the sites as well as observations when on site for interviews.

2.5.1 Observational access

Access to meetings was sought in the initial letter of invitation. Further verbal clearance for my observational work was sought from all participating organisations by the Chair of the HImP group in advance of the observational work. This also helped to allay any suspicions of my intentions, and in so doing minimise any possible change in the behaviour by participants. In total, ten meetings were observed and three development days (see Appendix H). Meetings were of the HImP/HAZ Boards or strategic groups, or the programme management group. In two localities these groups merged and re-organised into one group during the study period. By observing more than one meeting, in various locations and contexts within a site, consistent behavioural patterns can be identified, increasing the reliability of observations (Alder and Alder 1998). In one study site, only one meeting was observed. This was because formal HImP structures were not developed until half way through the study period.

2.5.2 Field notes

Detailed notes were made during meetings and written up as soon as possible afterwards. Notes were also made of any informal discussions with partners that happened before or after meetings (and also interviews). Notes were recorded in a special book during observations, and tried to record verbatim the flow and content of discussions. However, this was not always possible when the conversation was heated or intense, in which case the essence of what was said and by whom was captured. A cover sheet was also filled in directly after each meeting (see Appendix I). The sheet recorded the date, time and location of the meeting (Burgess 1991; Silverman 1998) as well as a number of other issues such as the main items addressed by the meeting, the most contentious points, which partners were the most vociferous or did not contribute to the discussion or debates and overall impressions of the meeting and the way it was conducted. A note was also made of individual participants, their position and any interactions, routines, rituals during the meeting (Alder and Alder 1998). This additional material helped to build up a picture of the roles, rules and relationships between people in the partnership (May 1997).

Data regarding meeting and seminars was considered in conjunction with the interview data and in light of the theoretical framework outlined in the literature review. Events

and perceptions which seemed particularly pertinent or relevant were typed up and coded on NUD*IST 4. For example, comments and conversations with people during or after seminars or meetings about their experiences of partnership were written up and coded. Minutes and papers from the meeting were also sought, not only as a reminder of the content of discussion but also as a record of the outcome of the decision-making process.

2.5.3 Comment on observational work

Observation work was useful to the study in a number of ways. Perhaps the most significant contribution was that it provided a valuable source of information about the case study site, helping the researcher to stay abreast of events that were rapidly changing. This included changes in the local and national environment as well as structural developments and issues facing the partnership. It helped to contextualise and understand the dynamics of each partnership and the issues that they were facing. One of the main criticisms levelled against observational research lies in the area of validity, since observers are forced to rely exclusively on their own perceptions (Alder and Alder 1998). However, a number of interviewees made reference to certain events or comments in meetings which were observed. The version of events or actions portrayed in these meetings was compared to the observations and reflections recorded in the field notes. On several occasions the recorded interpretation of events was verified in the field notes. For example, in one HImP meeting when the group were considering how the sub groups of the HImP should approach the issue of increasing voluntary sector participation, the local umbrella voluntary organisation's representative at the meeting was effectively ignored in discussions, despite having produced a paper on the issues in conjunction with the HImP co-ordinator. As recorded in the field notes, his wish to ensure each sub group had voluntary sector representation was effectively sidelined in favour of a more 'laissez faire' approach – each group deciding their own level of voluntary sector representation. This version of events was recounted back to the researcher unprompted, when the representative was interviewed several weeks later. Conversely, it was often revealing and informative to the analysis when significant events or behaviour perceived to have taken place in meetings, whether observed by the researcher or other attendees, were not identified by other interviewees present at the

meeting, indicating, perhaps, a lack of sensitivity or awareness of an issue or behaviour and its impact.

Observing actors in their natural settings is not necessarily a better way of getting at the 'truth'. As already noted, the presence of an observer can not only lead to alteration of actors' behaviour in settings, but, more importantly, it may lead to actors taking a particular position in relations to each other, depending on their respective organisational roles and the purpose of their interaction (Allen 2000, pp.135). In some meetings there was definitely a feeling of formality, which seemed to disrupt the flow of conversation and limit the topics discussed.

One approach to improving the validity of observational data is to use an analytical inductive methodology. Here issues or propositions emerging from interview data are either tested for negative cases or against observational (and other sources of) data. Observational data can help verify or 'triangulate' these findings. The two examples outlined in this section illustrate this point, when multiple independent measures (interview and observation) of the same phenomenon concur i.e. the researcher observes the phenomenon and independently the informant makes the same claim (Huberman and Miles 1998). The convergence of issues or propositions means any assertions about the data are more likely to be perceived as 'grounded' and universal (Alder and Alder 1998).

2.6 Documentary evidence

Institutionally generated information can reveal a great deal about the cultures and operation of institutions (Miller 1997). Documentary data allows previous processes and events to be analysed in an unobtrusive manner. Unlike interviews or observational methods, this kind of data collection is non-reactive, removing the possibility of bias (Bryman 1989). Documents can act as a useful source for corroborating attributional data (information relating to sites, organisations or individuals) and perceptions of previous events. Analysis of documents can provide information on issues that cannot readily be addressed through other methods (Bryman 1989) and is likely to be relevant to every case study (Yin 1994). A number of studies of health partnership have used

documentary analysis (Cooksey and Krieg 1996; Cornish, Chris et al. 1997; Costongs and Springett 1997; DoH 1998a; Green 1998; Elston and Fulop 2002).

Documents can tell us a great deal about how events were constructed, the reasons employed as well as providing material upon which to base further research (May 1997). They can also give access to data beyond the time spent in field and information about individuals who are fairly inaccessible to other data collection methods, such as senior executives (Bryman 1989).

Documents can be analysed in quantitative and qualitative ways, using a number of different approaches (May 1997). Silverman (1993, pp.61-62) notes four: content analysis, ethnographic analysis, semiotics and ethnomethodology. However, documentary analysis is one of the least explained research techniques in the literature (May 1997, pp.158). It has been criticised by some who argue that it does not constitute method at all (Platt, 1981, pp.31 quoted in May 1997, pp.158) or those who point to its misuse; researchers, for example, frequently fail to say how documents were used (Silverman 1993; May 1997; Miller 1997; Manning and Cullum-Swan 1998). Furthermore, inexperienced researchers are prone to the naïve assumption that the content of documents represents a reflection of social reality (Silverman 1993; May 1997; Miller 1997; Manning and Cullum-Swan 1998). However, what people decide to record is often the product of carefully controlled or manipulated processes. What to leave in or take out is informed by decisions that relate to the social, political and economic environment of which they are part (May 1997; Miller 1997). Rather than reflect a social reality, documents construct a version of events. Documents, therefore, cannot be treated as neutral artefacts that independently report 'true' events, as a positivist perspective would purport, but should be read 'as attempts at persuasion'. The meanings contained within the text are important to achieving this purpose. According to Scott, meanings codified can be inferred at three different levels: those *intended* by the authors; those *received* by the audience; and those *internal* to the document (Scott cited in May 1997). These need to be considered if a researcher is to grasp a document's significance. While the intentions of documents and their authors need to be considered,

May (1997, pp.165) argues that they also need to be linked to the social context in which they are produced.

This study took the approach to documentary analysis suggested by (Atkinson and Coffey 1997): that documents should be analysed for what they are and what they are used to accomplish. A range of documentary material was collected from study sites. This varied from site to site depending on availability (see below). Documents related to the working of partnership and the partnership agenda were mainly produced over the study period. However, additional material relating to the partnership prior to the study period was also collected where available. Documents fell into the following categories:

- Partnership process documents: HImP strategies, action plans, evaluation documents, communication documents (newsletters, consultation documents)
- Partnership functioning documents: HImP/HAZ minutes, constitutional documents (i.e. terms of reference)
- Partner organisation documents: annual health reports, Healthy City reports, community plans and Community Care Plans, Service and Financial Frameworks (SaFFs) and Joint Implementation Plans (JIPs) (where available) and health strategy/policy documents etc.

The study was also informed by the findings of an analysis of 50 randomly selected HImP strategy documents (Elston and Fulop 2002) (see Appendix J). The analysis sought to identify the different structures of partnership, their stages of development, their membership and some assessment of the quality of interaction and processes that had been used to achieve HImP strategies, with a number of qualifying caveats (Abbott, Shaw et al. 2004).

2.6.1 Comment on documentary analysis

Although documentary analysis can be a useful method for understanding and interpreting events, it was important to be conscious of the limitations set out above. When analysing documents, careful consideration was given to their place in

organisational settings, the cultural values attached to them, and their distinctive types and forms (Atkinson and Coffey 1997). Interpretative factors involved in their construction were also borne in mind: who wrote them, for what purpose, who was the audience, and what knowledge was required to understand the language used (Hammersley and Atkinson 1995). The policies, procedures and structures outlined in HImP strategies, for example, might not be a 'true' reflection of local partnership or practice, or indicate that the policies contained within them were being implemented (Abbott and Gillam 2000). Producing the HImP strategy was an integral part of a health partnership's work, setting out its scope and direction. However, it was also a document produced for external consumption (Atkinson and Coffey 1997), a legally required document, endorsed with the signatures of partners. Consequently its contents were likely to be shaped by what each of the constituent partners perceived to be important or expected, and by differing organisational pressures acting at local and national levels (Miller 1997), such as national guidance on HImPs. Thus, the content of HImP strategies was scrutinised to identify what and how health problems were presented. In particular, careful attention was paid to the rhetorical features of HImPs: the manner and language in which problems were couched in order to persuade readers about their claims (Atkinson and Coffey 1997). In so doing, an indication of the predominant paradigms that belayed their construction was sought. However, analysis of the progress on policy from working groups to document was not possible due to the underdevelopment of sub-groups in all sites.

Analysis was also undertaken in conjunction with other documents (such as minutes of meetings, needs assessments etc) since organisational texts are frequently cross-referenced or inter-linked (Atkinson and Coffey 1997), as well as in conjunction with my observational and interview data. Documents were analysed as to how they related to themes uncovered in the study and to verify or corroborate evidence collected by other methods. In addition, minutes of meetings were also used to identify who and how frequently partners attended meetings as an indication of the importance attached and commitment to HImP partnerships.

Documents provided useful reference points to confirm or question people's accounts of events as well as to check factual information such as attendance at meetings. The content of partnership documents (i.e. terms of reference) and policies and assertions could help corroborate events recounted in interviews. While documents can capture events or thinking at a point in time, they can also become quickly outdated. Of the three main methods of data collection from sites, documents were perhaps the least helpful in the analysis of partnership process and development. The number of changes in health service organisation made it difficult to get copies of some historical documents. In some local authorities new unitary organisations had been created, so historical documents related to other areas. There was also a very large number of documents, held by many different gatekeepers or organisations. This was because there were multiple partnership types, with large structures, groups and sub-groups, each with large membership, and all at different stages of development. Although the study focused on the strategic elements of partnership, the genesis of their policy work often emanated from the lower tiers of partnership. Identifying and collecting all relevant documents, let alone analysing them all was impracticable with the resources of the study. It was therefore necessary to be judicious in selection. This usually meant following up on key documents identified by respondents during the interview. Relatively little time was spent on a more rhetorical analysis of contents, to unpick the conceptual approaches and persuasive mechanisms used to convey internal and intended meanings. This was perhaps appropriate, given the focus of the study on the determinants and process of partnership. Studies focusing on the *process* and *outcome* of partnership might be expected to put greater emphasis on these kinds of documents (Lawrence, Phillips et al. 1999; Cloke, Milbourne et al. 2000).

2.7 Analysis of case studies

An overview of each case study site was written up in brief, providing first impressions of key issues, factual information about the sites, partnership structures and relevant historical events etc. Each synopsis was kept as an aide-memoire to sites.

As noted in Section 2.4, data (primarily interviews) was coded as themes, issues and patterns electronically on NUD*IST 4. Coding and categorisation of data was refined as analysis progressed. Study sites were analysed and written up for each theme and issue.

Patterns in the empirical data were matched to those predicted by theory for each study site (theoretical replication) as well as used for explanation building (Yin 1994). Relevant and useful analytical frameworks began to emerge as familiarity with the data increased and conceptual links made. The use of multiple theoretical frameworks has often been used to study decision processes, mostly notably in Graham Allison's study of the Cuban missile crisis (Allison 1971). In part, this has been because of the difficulty of developing a unique theoretical model (Langley 1999). Many of the theoretical perspectives used to analyse partnership focus on different elements of partnership formation, development and outcomes (Gray and Wood 1991), each with a slightly different coloured lens. Certainly, identifying influences and patterns of behaviour was an iterative process and occurred after several rounds of reflective writing, the level of analysis moving to a higher plain with each cycle. However, no one theoretical framework seemed to capture comprehensively the experience of study sites in their explanation of the nature and development of partnership. For this reason, findings from study sites were re-written and woven into narratives, reflecting the most appropriate theoretical frameworks. These three were outlined in Chapter 1.

The strength of themes, issues and patterns was assessed by *data triangulation* (e.g. multiple correspondence between issues or themes identified using the same data collection method i.e. interviewing). This was assessed quantitatively using the computer software (i.e. counting the number of times an issue was identified) and through a process of *methodological triangulation*, corroboration of data collected by another method (Flick 1992; Silverman 1993; Keen and Packwood 1995). Using such techniques on process data can help expose *ex post* rationalisation by actors – a process whereby an actor might present a certain view of events or justify an action, perhaps because the actor has an invested interest in doing so. The findings from each case study site were then compared to identify similarities and differences. Comparisons were made using the two dimensions used for site selection, facilitating an assessment of the impact of these factors. These preliminary findings were sounded out with several acquaintances based in health authorities outside the study areas and other individuals encountered at national seminars. This gave some validity to the case study narratives and their generalisability to other sites. However, validating process did not extend to

the theoretical interpretation, as practitioners' degree of knowledge of these, let alone their reflections, was not sufficient.

Similarities or patterns that existed between case study sites were explored and theoretical generalisations developed and tested. This enabled some theoretical assertions outlined in Chapter 1 to be tested (Yin 1994). Explanations were sought for deviant cases and were used to refine my theoretical generalisations (Silverman 1998). Analysis did not occur in a neatly defined timeframe but began with data collection, gathered momentum as this proceeded, and finished sometime after all data was collected (Mays and Pope 1995). In this way the analysis and results of the study were firmly located or 'grounded' in the data collected (Glaser and Strauss 1967; Martin and Turner 1986).

2.7.1 Comment on case study analysis

A large quantity of rich, qualitative data was collected for this thesis using a variety of methods, often complex and ambiguous in nature. Making sense of such 'messy' data was not a straightforward process, let alone attempting to extrapolate theory (Langley 1999). Trying to understand the interaction and the processes at work in partnership and their impact, in essence trying to unravel the cause and effect relationships at play, did not just reveal themselves after one or two readings of the transcribed text.

Process theories attempt to explain in terms of a sequence of events leading to an outcome (Langley 1999). But an outcome can arise from another process, event or output. The sequence of events can be multiple and may feed back on one another. Important events may not be known to the researcher. Barriers or boundaries between processes, events and outcomes may not be well differentiated. At times it was difficult to identify the chronological sequence or proximity of processes and events, or which processes or events were distinguishing influences. Good causal arguments require these (and other) characteristics to be carefully considered and clarified (Gerring 2001). Furthermore, relevant thought processes and motivations inside actors' heads driving their behaviour, may be fleeting, whimsical and nigh on impossible to capture – recantations are open to many biases. Analysing the process data was therefore a

difficult and protracted task, taking far longer than anticipated. It relied on a degree of intuition and at times a creative leap of faith to fill small missing pieces in the process jigsaw.

Langley (1999) identifies seven distinct strategies in the literature (excluding critical theory/discourse analysis approaches (Lawrence, Phillips et al. 1999)) to make sense of organisational data, each of which has its strengths and weaknesses when it comes to generating simple, accurate, generalisable theory – desirable characteristics of theory, according to Weick (1999) (cited by Langley (1999)). The strategies are:

- Narrative (a story which captures richness and complexity but emphasises salient aspects to create a sense of déjà vu)
- Quantification (process data is systematically reduced to quantifiable variables, amenable to statistical analysis)
- Alternative templates (use of multiple theoretical frameworks to analyse data)
- Grounded Theory (systematic development of categories from the data which integrate core concepts into a coherent whole)
- Visual mapping (the visual presentation of multiple variables and processes, with time but with less abstract theorising)
- Temporal bracketing (breaking process data in small brackets or periods of time, allowing analysis of feed back mechanisms of structuration)
- Synthetic strategy (developing global measures for data to describe events which are used to describe different process and identify regularities in order to form theory)

As detailed in the preceding text, this study used a combination of these approaches at different stages in the analysis to explore and make sense of the data. Essentially, it used the alternative templates strategy, using three theoretical frameworks outlined in Chapter 1 to examine different elements of partnership. This approach can be categorised as a ‘grounding strategy’ as it provides concepts that can be used in the

construction of narrative and visual maps. Several chapters use these strategies to present and understand the data located within the broader context of the theoretical framework being addressed. Unlike Grounded Theory (Glaser and Strauss 1967), the approach is heavily rooted in deductive reasoning, although this study used some inductive reasoning. This was because the theoretical frameworks were not chosen *a priori* (although the researcher had knowledge of potentially helpful theoretical perspectives before data collection began); rather, as noted above, they were identified as the analysis proceeded.

A critic of this approach might point to the different assumptions on which the theoretical perspectives are based, which may be conflicting or ambiguous (Parsons 1995). Any attempt at melding theoretical perspectives may be regarded inappropriate or misguided. Theoretical clarity must be maintained by keeping different lenses separate (Langley 1999). However, this thesis seeks to use the different 'theoretical lenses' to shed different perspectives on partnership, an approach others have taken (Loxley 1997). Here theories or explanations are based on metaphors, which lead us to see and understand organisations in distinctive yet partial ways. This can provide a powerful means of deriving insight as similarities between the metaphor – organisations as machines, living organisms, cultures etc – and the comparative object (partnership) bring certain elements to the fore, while forcing other aspects into the background (Morgan 1986). Confrontation between different theories or metaphors can identify gaps and help generate insight (Langley 1999).

2.8 Ethical issues

Ethics concern the moral conduct of human beings; the principles and rules that guide or govern our behaviour towards other individuals. Consideration of ethical issues involves thinking about norms, values, rights and wrongs, being good or bad, and what ought and ought not to be done (Gillon 1985). Although there are many divisions of moral philosophy, this thesis is concerned with normative ethics in research – what type of research should be conducted and how. In health services research, particularly research concerned with medical or behavioural interventions, there are many ethics issues or concerns. This is because the conduct of the research and/or the behaviour of the researcher may have significant consequences for the health or well-being of those

individuals being studied. Although in organisational research these may appear to be less severe than the potential consequence posed to individuals by biomedical research, there are still issues of power and control at play that may impact on human dignity (Cassell 1980). This is because of the close links and interaction between the researcher and the host case study (Pettigrew 1997) and the degree of trust engendered. A useful and well-established framework for thinking through ethical issues in health services research is that developed by the Americans Beauchamp and Childress (Gillon 1994). This uses four, basic *prima facie* moral principles:

- Respecting *autonomy* (ensuring informed consent and confidentiality, and avoiding deceit, all of which require good communication)
- *Beneficence* and *non-maleficence* (the intervention is to provide a net benefit, and minimise harm, whilst being clear about how and to whom the risks are apportioned)
- *Justice* (acting with equality and fairness, particularly when adjudicating between competing claims over resources, people's rights and laws)

Prima facie means that the principle is binding unless it conflicts with another moral principle – if it does then there is a need to choose between them. Application of these principles also requires an assessment of their scope with respect to us as individuals, healthcare workers, researchers/professionals. As this study was not evaluating a medical intervention purporting to convey a direct health benefit to individuals but was focused on the organisation of health services, respect for human dignity or autonomy was perhaps the most important principle to heed (Cassell 1980). Ensuring informed consent and confidentiality for all respondents was not only appropriate for the study design but also reduced the possibility of harm arising from frank comments or criticisms of colleagues or other organisations. If these were attributable in the public sphere then there could be consequences that could affect the well-being of the person concerned (i.e. difficult work relations or loss of job or funding). The benefits of participating in the study were more likely to be indirect and general in scope, with learning, through case study feedback and journal publications, potentially leading to more effective partnership working, although the study made no claims about

evaluating the effectiveness of partnership. Achieving this benefit implies that the study was designed and conducted according to the methodological standards widely recognised amongst social scientists. For these reasons, ethical approval for the study design was sought from and granted by the university ethics committee.

In conducting the study, several minor ethical issues arose relating to autonomy and beneficence. On a number of occasions respondents wanted to know either which other individuals had been interviewed or what other case study sites were involved in the study. Furthermore, several respondents were keen to know how their partnership was doing in comparison with others. On these occasions, respondents were either reminded of the anonymity and confidentiality that had been negotiated as part of the study, or, in the latter instance, were given responses which were very general and did not imply access to confidential material or knowledge that might have been attributable. This was not always easy when interviewing senior figures, some of whom had granted access in the first place, which meant there was a strong urge to reciprocate their generosity in giving organisational time and information (Pettigrew 1997). Autonomy came into conflict with the moral principle of beneficence – that the host organisation stands to gain from the research arrangement. Furthermore, giving specific feedback to individuals (in or after interviews/observational work or study site workshops) before data collection had finished may have unduly influenced behaviour in case study sites. This would have undermined the study design, not only contravening scientific norms for conducting such research but possibly creating misleading conclusions, reducing the study's benefit.

Fulfilling the moral obligation of beneficence also presented a challenge as the abolition of health authorities (NHS Executive and CHCs) and the development of all PCGs to PCTs was announced shortly after data collection finished and enacted before I completed the PhD. During this time, HImP partnerships became HIMPs, and in the most deprived areas were then absorbed into LSPs. Nevertheless, a four-page synopsis of the research findings was sent to participating organisations or partnerships still in existence (i.e. HAZs). Additional dissemination of the results not foreseen when the research was originally conceived took place through the Public Health Continuing

Professional Development Network in North London and other emerging forums for sharing knowledge amongst professionals. This provided some compensatory benefit.

The study, therefore, presented some minor ethical issues that were addressed while conducting and writing up the research.

2.9 Conclusion

A detailed comparative case study methodology was considered the most appropriate way of investigating the complex social relationships involved in partnership. The use of different methods of data collection in four sites over a year and data analysis through an iterate process, drawing on three established theoretical frameworks, enabled a full and rounded understanding of the nature and development of local strategic health partnerships in case study sites and possibly further afield. In this way, the research questions set out in Chapter 1 were appropriately addressed. The following four chapters will now discuss the analysis of the data, each one using one of the three theoretical frameworks outlined in Chapter 1 to explore and explain HImP and HAZ partnerships.

Chapter 3 – From the outside in: the influence of command and control mechanisms on partnership

3.1 Introduction

This chapter is about the context in which partnership (as *co-ordination*, *collaboration* and *participation*) was trying to be achieved. It explores the impact of central government vertical command and control mechanisms on the nature of relations and the development and functioning of HImP and HAZ partnerships. It contrasts with subsequent chapters which examine the nature and development of horizontal relationships within these partnerships. These mechanisms of bureaucratic co-ordination were the single most important influence on strategic health partnerships (identified by respondents in all study sites). Their application and impact provide a contextual background and framework of analysis for the remaining chapters of this thesis. It is shown how the government's use of these mechanisms increased as health partnerships developed, and how this impacted significantly on local horizontal structures, relations and processes, and ultimately on partnership outcomes. It addresses the first research question: how did the hierarchal command and control measures used by government influence the development, interaction, process and outcome of health partnership? In so doing, it begins to examine the inherent tension at the heart of the government's reform of the NHS.

In Chapter 1 it was argued that government reforms of the NHS represented a shift away from markets and competition towards co-ordinating activity through partnership (Ferlie and McGivern 2003). Hierarchical commands created new decentralised organisational forms (i.e. PCGs) and encouraged the formation of strategic health partnerships (HAZs and HImPs). The rationale for these reforms was to create a more responsive, innovative and democratic health service at the local level, reducing the centralised control of NHS bureaucracy which had stifled innovation (Blair 1998). Partnership was the mechanism for accomplishing these and other aims set out in the Third Way philosophy. Policy was enacted through legislation, circulars and directives,

default powers (ministerial intervention), appellate functions of ministers (HAZ bids) and financial measures.

Hierarchical command, creating decentralised organisational forms and partnerships, was accompanied by hierarchical control. Partnership was to be driven by performance (DoH 1997). In keeping with broader trends in the management of public services (Ferlie, Ashburner et al. 1996; Rhodes 2000b; Klein 2001), the government created a number of new national organisations to set quality standards and audit activity, and employed a mixture of output and behavioural controls to monitor progress towards achieving targets and minimum standards. These control mechanisms were accompanied by various incentives and sanctions to encourage the appropriate behaviour (Bennington 2000; Dixon 2001; Klein 2001; Leach and Percy-Smith 2001b).

An inherent tension in government reforms therefore seemed to exist between its emphasis on innovative, democratic partnerships at the local level, which required flexibility and autonomy to tackle difficult local issues in an innovative and appropriate manner, and the use of hierarchical co-ordination mechanisms which sought to impose control over local activity. This chapter explores this tension.

Drawing on hierarchy as an analytical framework for the co-ordination of organisational activity, this chapter charts the nature and influence of command and control measures over the study period and their impact on the development and functioning of health partnership, with respect to its structure, interaction, process and outcome. The mechanisms of mandatory co-ordination employed by the government to implement its reforms are shown in Appendix K on page 399.

However, hierarchical co-ordination is not considered in terms of static structures or formal institutions but as a process (Pierre and Peters 2000) in which commands and controls are enacted by actors. Command mechanisms are included as they provide the parameters and context for control mechanisms, and were identified as influential in the empirical literature reviewed in Chapter 1.

Table 3.1 sets out the command and control mechanisms used by the government. Control mechanisms are categorised as output and behavioural controls, although some

Table 3.1 Hierarchical command and control mechanisms used to co-ordinate government reforms on partnership

Classification of co-ordination	Mechanisms employed	Locus of control
Command (legal)		
	<ul style="list-style-type: none"> Green and White Papers and subsequent parliamentary acts 	<ul style="list-style-type: none"> Duty of partnership on health and well-being Creation of PCGs as legal entities Amendment of previous health and social care acts on management of joint funding and provision
Control (outputs)		
	<ul style="list-style-type: none"> Policy documents (i.e. NSFs, consultations) 	<ul style="list-style-type: none"> Health outcome targets Process output indicators and targets
Control (direct behavioural)		
	<ul style="list-style-type: none"> Policy documents (i.e. NSFs, consultations) 	<ul style="list-style-type: none"> Creation of HImPs, HAZs and PCGs Setting minimum behavioural/service standards
	<ul style="list-style-type: none"> Policy instruments (directives and documents) 	<ul style="list-style-type: none"> Indicating types of behaviours and roles of different organisations (including partnerships)
	<ul style="list-style-type: none"> Finance and resource streams 	<ul style="list-style-type: none"> Regulating expenditure for HAs and PCGs in line with changing organisational roles
Control (indirect behavioural)		
	<ul style="list-style-type: none"> Incentives 	<ul style="list-style-type: none"> Additional and conditional (ring-fenced) resource streams for partnership Granting of 'freedoms and flexibilities' 'Earned autonomy' for organisations based on performance
	<ul style="list-style-type: none"> Sanctions 	<ul style="list-style-type: none"> Reduced access to resources Reduced autonomy through executive or ministerial interference in partnerships/organisations

mechanisms use both types of control. Behavioural controls are further categorised as direct and indirect; controls which directly set out roles and tasks etc, and controls

which indirectly seek to encourage the attainment of certain behaviours and outputs through offering rewards or imposing sanctions.

The chapter also draws on the systems model of organisational control outlined in Figure 1.4 in Chapter 1. This helps distinguish and separate out the influence of command from control measures on the development of health partnership.

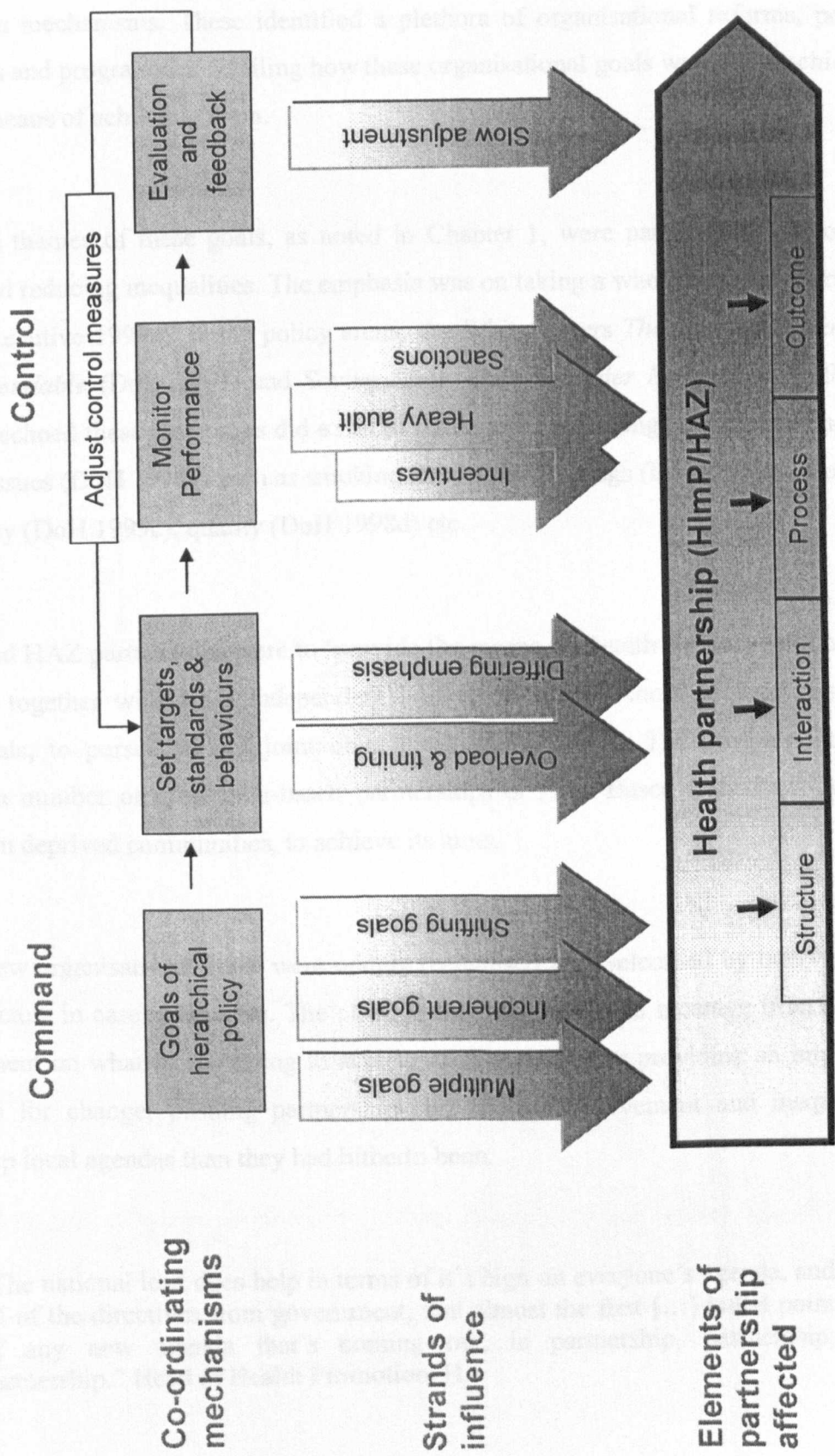
The chapter begins by examining the nature and influence of command mechanisms employed by the government to promote partnership around health issues and convey the new goals of the NHS hierarchy. It then moves to consider the nature and influence of output and behavioural control mechanisms used by the government, such as performance management and the use of incentive and sanctions. The influence of these measures on the structure, interaction, process of partnership development as well as outcome of partnership is identified. These issues are explored further in subsequent chapters. A diagrammatical summary of the influence of command and control mechanisms on partnership is outlined in Figure 3.1.

The chapter provides evidence that central command and control mechanisms restricted the latitude of local organisations to form horizontal relations, and further, curbed the autonomy of health partnerships to respond to the local issues. However, it was not the intrinsic use of central command and control mechanisms that was detrimental to lateral relations and autonomy, rather their structure and changing emphasis which undermined their original intent.

3.2 The new hierarchical goals – a positive force for health and partnership

This section considers the influence of new hierarchical goals set by the government and their influence on attitudes and perspectives of respondents at a local level. It then considers the operational content of these goals which led to a multitude of policies causing policy overload. Incoherence between operational content of goals was also evident. Finally, it shows that hierarchical goals shifted, resulting in a change in policy emphasis away from health towards health service issues.

Figure 3.1. Influence of command and control mechanisms on the development of health partnership



Within a year of taking office, New Labour set out its new hierarchical goals, using a variety of command measures such as legislation, circulars and other formal co-ordination mechanisms. These identified a plethora of organisational reforms, policy initiatives and programmes detailing how these organisational goals were to be achieved and the means of achieving them.

Common themes of these goals, as noted in Chapter 1, were partnership, improving health and reducing inequalities. The emphasis was on taking a whole systems approach (NHS Executive 1999a). In the policy arena, the White Papers *The new NHS: Modern and Dependable* (DoH 1997) and *Saving Lives: Our Healthier Nation* (DoH 1999a) strongly echoed these themes, as did a raft of other policies relating to health and health service issues (DoH 1998e) such as smoking (DoH 1998f), drugs (DoH 1998g), teenage pregnancy (DoH 1999c), quality (DoH 1998d) etc.

HImP and HAZ partnerships were to ‘provide the means for health and local authorities to work together with other independent bodies, as well as local communities and individuals, to pursue [these] joint objectives’ (DoH 1999d). The government also created a number of other area-based partnerships or Area Based Initiatives (ABIs), located in deprived communities, to achieve its aims.

These new organisational goals were widely recognised and welcomed by interviewees in all sectors in case study sites. The clear, strong and consistent message from central government on what it was trying to achieve was perceived as providing an important stimulus for change, pushing partnership and health improvement and inequalities higher up local agendas than they had hitherto been.

“The national lead does help in terms of it’s high on everyone’s agenda, and all of the directives from government, that almost the first [...] bullet point of any new agenda that’s coming out, is partnership, partnership, partnership.” Head of Health Promotion, HA

The government's new policy goals were accompanied by a change in attitude by senior officers within HA and LA towards existing partnerships which were working on the health improvement and inequalities issues, such as Healthy City or Health For All partnerships, taking them from the 'margins to the mainstream':

“[T]he work we used to do around inequalities, it wasn't recognised by government as the way to go, really. The Health of Our Nation didn't sort of comply very much with our programme. So we were working very much to the WHO agenda. Now things have changed within central government in their recognition of inequalities and all those sort of things, the HAZ programme, social determinants of that, we're almost becoming mainstream.” HFA Co-ordinator

Membership was either changed to include senior officers or merged into the new HIMP structures, moving the agenda from a programme to a strategic approach.

The structural reforms to the NHS, particularly the replacement of markets and contracts with partnership and service agreements as a means of achieving the new goals, also resulted in a perceived change to the nature of relations between HAs and NHS Trusts. Attitudes were reported as less competitive and more co-operative and trusting.

“[Previous internal reforms] militated against the notion of effective collaboration and partnership, with an undue emphasis on competition and on protectionism...and also on a lack of preparedness to share information and data. So we've had to unravel all those kind of cultural and behavioural elements, and particularly bring Trusts, who actually have been very receptive to coming in, once they've understood the agenda.” CEO, HA

The policy goal of adopting a whole systems approach to the reform agenda (NHS Executive 1999a) was also filtering down to local actors, with officers beginning to perceive their organisations as part of a local health economy, interdependent on other organisations to deliver health improvement.

“No one part of this fabric of organisational partnership and all the rest of it can be *independent* of all the other influences that occur [...] Every part of the NHS locally, in this sense, is interdependent. That’s a big change from the previous regime under the Conservative government, whereby whatever the internal market, independence, or quasi-independence, was a positive sort of goal.” CEO, HA

The policy goals promulgated by other government departments such as the Department of Environment, Transport and the Regions (DETR) in the White Paper *Modern Local Government: In touch with the people* (DETR 1998), also promoted goals similar to those of the DoH; partnership, health and well-being and social inequalities/exclusion.

On housing policy, the government was advocating a partnership approach, encouraging LAs to work with HAs in placing people in supported housing. LA policy such as Best Value (DETR 1998) and the Neighbourhood Renewal Strategy (NRS) (Social Exclusion Unit 1998) also emphasised working in partnership, particularly with the voluntary sector.

As health became more ‘fashionable’, senior officers from Social Services (SS) and other LA departments quickly got involved in health partnerships. The inclusion of health in the criteria for SRB partnerships also helped switch LA officers and council members on to health as a priority.

The policy agenda also encouraged working with the voluntary sector (DoH 1998e). For its part, the voluntary sector could relate to the organisational goals of partnership, inequalities and health improvement.

“[T]he role of the voluntary community sector is changing significantly in the city anyway, and that's come out of some of the government initiatives around Social Exclusion Unit papers and so on, highlighting the need for the statutory sector to work more collaboratively with the voluntary community sector.” Director, Voluntary Sector

The central government command mechanisms of legislation and policy documents, pushed and promoted the new goals of the hierarchy and, along with the accompanying structural reforms in the NHS, helped ensure the ideas were embedded in the lower tiers of the hierarchy. For some organisations this was a novel agenda but for others, such as some Community Trusts, it was ‘nothing new’. Indeed, in several sites partnership working was fairly well developed, albeit not at a strategic level.

Government policy helped motivate individuals to become involved in health partnerships, particularly those actors who personally identified with the content of the agenda and who had previously been working on similar agendas (such as the Healthy City initiative). It not only provided legitimacy for the activity but also the agenda which now recognised the determinants of health and health inequalities beyond the health service. The new agenda, therefore, built on a small bedrock of existing partnership work. The emphasis of the new national agenda also helped projects gain support beyond their traditional home of health promotion (ea). Addressing health inequalities through partnership was moving from health promotion into other HA departments and into the LA. In Middleton, for example, the HA in conjunction with the LA embarked on a community research project which trained and employed local people to assess local health needs. This was reported as a noticeable change in approach. As one LA director commented about the local HA, ‘[this was] a far cry from where they were, which was appointing an external consultant [...] to come in and actually do that business.’

However, despite the apparent consistent messages on government goals across the public sector, there were a number of issues relating to the enactment of these goals which served to undermine the formation, functioning and outputs of partnership. These are indicated by the three left-hand arrows in Figure 3.1 that fall under the command element of the co-ordination mechanism. The influence of each is explored next.

3.2.1 Multiple commands and policy overload

While the government’s goals were relatively few and clear, the sheer number of policy commands emanating from central government to direct the implementation of these

goals in the periphery created ‘policy overload’. As part of the modernisation agenda, government departments (DoH, DETR, DfEE etc) produced a deluge of new policy documents and circulars, each of which detailed priorities and structural reforms for statutory organisations at the local level. These set targets and standards, and employed a range of output and behavioural controls. Table 3.2 gives some examples.

On top of this plethora of policy commands, many government departments sought to promote partnership working by instigating their own ABIs. These are shown in Table 3.3. ABI status required the establishment of local partnership boards in order to administer local funding. All case study sites were involved in a number of ABIs.

Table 3.2. Examples of policy documents with their targets and standards

Policy document	Targets or standards	Focal organisation
Saving Lives	Four health outcome targets on mental health, accidents, cancer and CHD	HImP partnerships
Mental health NSF	Behavioural standards and output targets	NHS and Social Services
Older People NSF	Behavioural standards and output targets	NHS and Social Services
Modern Local Government	Behavioural standards	Local government
NHS Plan	Output targets	NHS organisations
National Cancer Plan	Behavioural standards and output targets	NHS organisations

There were also pilot schemes (such as Pathfinder, a regeneration partnership sponsored by the Department of Trade Industry (DTI)) and ‘trailblazing initiatives’.

Policy was introduced incrementally, in fragments, some of which did not refer to each other and did not appear to be in any sequence or to relate to a bigger policy picture. Together with the multitude of departmental policies, this created a ‘complex’, ‘complicated’ and ‘confusing’ web of policy initiatives and structural reforms in each locale, which were difficult to map and whose links were in constant flux during the study.

Table 3.3. Examples of different departmental Area Based Initiatives (ABIs)

DoH	DfEE	DETR	Social Exclusion Unit
<ul style="list-style-type: none">• Health Action Zones (HAZ)	<ul style="list-style-type: none">• Employment Zones (EAZ)• New Start• Education Action Zones (EdAZ)• Sure Start	<ul style="list-style-type: none">• Single Regeneration Budget (SRB 1-6)• New Deal for Communities (NDC)• New Commitment to Regeneration (NCR)	<ul style="list-style-type: none">• Neighbourhood Renewal Strategy (NRS)

The rate of production of policy commands left some partners reeling as they tried to take on board new initiatives and programmes. It created a reactive atmosphere where some partners (i.e. LAs trying to respond to the array of ABIs) were struggling to keep up with the agenda and therefore were unable to see the broader picture.

“[I]t’s quite difficult to be able then, to step back and actually say, now let’s take stock of this because the speed at which things come at you in order to deliver things now is much more intense than it was two or three years ago.”
Director, LA

Statutory agencies became swamped with ‘too many priorities’ – so many that not all could be accommodated at once. In this environment, HImP partnerships were one priority but not *the* priority for HAs and their partner agencies. Furthermore, government pressure to drive through the modernisation agenda resulted in individual departments pressuring relevant statutory organisations to respond to their priorities.

For local statutory organisations, this created a tension between accomplishing intra-organisational priorities, departmental priorities for their organisations, and inter-organisational priorities relating to the numerous partnerships or ABIs, health or otherwise. While striving to accommodate this tension, many statutory partners found they did not have the organisational capacity to respond fully to all the demands placed on them.

“[W]e want to engage with other agencies, I think we struggle because we, you know, we have too many meetings and other commitments [...] and our colleagues do as well, and it’s so difficult.” DPH

In deciding where to place their efforts, many organisations focused on those policy agenda items for which they were directly accountable – those of their department – and for which there were potential consequences if there was implementation failure. Thus, greater efforts were placed on achieving departmental priorities rather than setting up and agreeing local priorities through partnership for which they were not accountable, even in sites where good links were already established between agencies. For the newly created PCGs, there was the additional pressure of developing their own organisational structures and processes. This further restricted their capacity to participate fully in developing local health strategy or partnership.

“[W]e’re pretty small organisations, I’ve got five, six people working for me. In reality, we could probably attend a partnership meeting every other day, and in capacity terms, PCGs are not up to that level of commitment.”
CEO, PCG

Nevertheless, statutory (and other) organisations did establish local health partnerships despite having limited resources to do so, by ‘relying on a lot of goodwill, and people finding a bit of time to lead the process when they’ve got other day jobs’, as one DPH put it.

The government emphasis on partnership, (i.e. HImPs) together with the profusion of ABIs, created ‘partnershipitis’ – an acute condition of excess partnerships and partnership activity. This resulted in much duplication of work, as key members of statutory agencies were involved in numerous different partnership initiatives discussing similar issues. With the capacity of statutory partners’ organisations stretched, ABIs had to compete with each other for partners’ resources. These factors served to undermine the formation of links between ABIs and created a degree of insularity between partnerships. One HAZ co-ordinator commented:

“It’s almost like we’ve moved from silos which are different organisations, so health, local authorities, voluntary you know, from the old silos of working to working in partnership silos.” Co-ordinator, HAZ

Thus, the large and demanding policy agenda served to undermine organisational capacity to respond to the health partnership agenda, even though the government's goals were readily understood and provided a positive impetus for partnership, and even though the mechanisms now existed to work in partnership.

3.2.2 Incoherent policy commands

An inherent assumption in the systems management model of control is that goals are not only clearly articulated and understood but that they are coherent and well co-ordinated and are not contradictory or become ends in themselves. This assumption also applies to the control mechanisms used to achieve these goals, i.e. the setting of targets and standards and the mechanisms to measure progress. It is an assumption supported by the literature on partnership which notes the importance of policy coherence and co-ordination. The previous section has noted the large increase in policy directives and guidance, but how coherent were these policy commands? And what about the coherence of accompanying control mechanisms used by the government? These questions are explored below.

While a number of policy themes or goals could be identified in policy documents emanating from different government departments, many respondents from statutory organisations across all sites argued that there were still areas of policy which were incoherent. Despite the appointment of a Minister of Public Health to the cabinet to improve cross-departmental working, plus improved links between departmental executives at a regional level, the production of joint guidance and directives to HAs and LAs, and the establishment of an inter-departmental HAZ team, nevertheless a 'silo' mentality together with differing priorities (Hudson 1997), inter-departmental competitiveness (Challis, Fuller et al. 1988) or oversight still appeared to persist between government departments, leading to poor co-ordination or a lack of joined up thinking on partnership, health improvement and inequalities.

“[W]e had a meeting this week with [the UK anti-Drugs Co-ordination Unit] and I raised that [incoherence on drugs policy] and they said ‘With the best will in the world’ they’re not going to get things working in partnership across Whitehall. They raised it, they tried to have those discussions but

things are still coming out separately from government departments.”
Health Promotion Manager, HA

Incoherence at the top of the hierarchy filtered down through the command and control mechanisms to the local level where it had a negative impact.

Incongruence in policy goals and the control delivery system confused local actors. For some respondents, incoherence was at the heart of government policy thinking; the government was encouraging innovation in local services in response to local need through health partnerships, while identifying local variation in service provision as unacceptable and laying down central priorities – a point also noted by some NHS commentators (Klein 2001). As one DPH put it:

“[W]hy bother to set up a system which allows local determination,
[when] the whole thing is driven from the top?”

Moreover, the policy command to produce a HImP strategy was not reconciled against existing statutory commands or requirements. HAs and LAs were already required to produce a whole host of other joint strategies on a range of issues, many of which were relevant to health or health service improvement, i.e. Community Care Plans, Community Safety plans, DAT strategies, education strategies etc, to name a few. Production of these documents already took up much officer time. The requirement to produce another strategy placed a further burden on agencies and left them struggling to link up documents and strategies in an effort to avoid duplication.

Respondents in all sites identified incoherence in co-ordination of command and control mechanisms between government departments. In the realm of command mechanisms, there was incoherence between various new health and partnership policy goals, between new and existing goals and between existing formal structures of vertical co-ordination (i.e. planning cycles, boundaries). Incoherence was also identified in elements of the control mechanism, whether it was differing departmental targets, an inconsistent approach to performance monitoring, different accountability mechanisms or different incentive structures. Examples of incoherence are provided in Appendix L

on page 400, showing where the locus on incoherence resided (command or control), indicating the impact on partnership, and the sites in which respondents identified them. Some of these examples only relate to sites where specific partnerships were present i.e. HAZ, Healthy City or Pathfinder etc. While the lack of coherence between government departments did not override the strong central messages to work in partnership and the local willingness to do so, it did serve to place obstacles in the development of partnership: the building of relations, the identification of aims and objectives, allocation of resources and the management of plans. It also created much duplication of effort and undermined the capacity of partners to participate in partnership. Unravelling inconsistencies required resources, persistence and creativity.

Nevertheless, despite a degree of policy incoherence, which hindered the development of partnership, many partners were still very motivated and committed to working in partnership and sought to make the best of the new agenda.

The government itself was aware of some policy incoherence. For example, some of the issues around duplication of partnership structures and monitoring on inter-ABI projects were highlighted by HAZ partnerships at regional conferences (Lannin 2002), while the CABI team noted the need for better streamlining and co-ordination of policy in its research for the DETR (DETR 2000a).

3.2.3 Shifting policy goals – from health to health services

In addition to the multiple policy commands and incoherent policy goals and control measures, the focus of policy goals shifted during the study period. The original policy goals outlined in the government's public health Green Paper in 1998 and the subsequent White Paper in 1999 – although primarily organised around ill health (cancer, CHD, and mental health) – explicitly recognised the wider determinants of health. HImP and HAZ partnerships were the vehicle for taking this agenda forward. However, late 1999 saw the beginning of a marked shift in emphasis of policy from health to health services, particularly to secondary care. This shift was a response to increased scrutiny of the Labour government's record on delivering its electoral pledges

on waiting lists and ‘postcode rationing’, and was fuelled by a succession of NHS ‘horror stories’ in the media, not least the public inquiry into child heart operations at Bristol Royal Infirmary and the Harold Shipman case. An impression of failed delivery led to Frank Dobson, the Secretary of State for Health, losing his post in a cabinet reshuffle to the then Junior Minister and ‘moderniser’, Alan Milburn in October 1999 (Klein 2001; Webster 2002). The appointment of Alan Milburn prompted a move away from a broader health agenda towards delivering NHS priorities (Asthana, Richardson et al. 2002). An illustration of this shift was the passing of responsibility for HAZs to the Minister for Social Care, John Hutton within two months of being in post. As one health promotion (HP) manager noted:

“Alan Milburn coming in, he doesn't seem to like HAZs.” HP manager

At the beginning of 2000, following the perceived failure by the NHS to cope with an influenza outbreak, the Prime Minister unexpectedly announced an increase in funding for the NHS (Klein 2001; Lannin 2002). New investment had to be linked to modernisation and reform (Webster 2002), with a strong emphasis on reaching targets or process outcomes. A dual agenda of service modernisation and performance management emerged. This was marked by the introduction of the NHS Plan in June 2000 which reaffirmed the government’s commitment to reducing waiting lists (a maximum two-week wait for cancer patients) and included a number of other process targets on cancer, CHD and MH (DoH 2000a). Although the Plan re-emphasised closer working between HAs and SS, possibly through the creation of the Care Trusts (for failing services), health partnerships were marginal to the document. HAZs were only mentioned in two paragraphs although a few more were given over to Local Strategic Partnerships (LSPs), another new local health partnership. At the same time a cabinet reshuffle saw the role of Minister of Public Health downgraded to Parliamentary Undersecretary of State for Public Health, with the position passing from Tessa Jowell to Yvette Cooper. Furthermore, the prevention and inequalities NHS modernisation team created by the Prime Minister in April 2000 did not include the new Undersecretary of State (Beecham 2000). Thus, the policy focus on long-term health gain shifted markedly towards short-term health service issues, a change noted in all case study sites in both HImP and HAZ partnerships.

“[W]hen I think the notion of a health improvement programme was first mooted, and the first draft guidance came out, it was very focused, it was about developing health. It wasn't about health services [...] It didn't include things about estates, and PFI hospitals, and waiting lists, and emergency admissions, you know, which is the business of the health service. It was much more public health orientated, and that was what people thought it was going to be.” CEO, PCG

Following the publication of the NHS Plan in June 2000, HAZs were directed to spend funds on cancer, CHD and improving MH. This was followed by a ministerial letter to HAZ partnership boards expressing an expectation that HAZs direct £500,000 of their funding towards addressing winter pressure and waiting list initiatives [Field notes]. Thus, a more health-service focused agenda was imposed centrally on HAZs, representing a shift away from examining the broad determinants of health, altering the original ‘bottom up’ philosophy of HAZs which aimed to develop local solutions to locally defined problems (Bauld, Judge et al. 2000).

“[T]hat has led to some difficult discussions as people have seen their ambitions thwarted because of the way the funding streams have been put together. So instead of it being like a process, which was a lot of the language of it, it's actually being driven. You can have a HAZ but you've got to spend the money this way.” Director, SS

For the new Secretary of State, HAZ partnerships were less important to the delivery of the NHS Plan, and therefore, no longer a national priority (Bauld, Judge et al. 2000). As a consequence of the hierarchy's shift in policy, HImP and HAZ partnerships had to refocus on delivering a more health service-orientated agenda. This was accompanied by a number of changes to funding arrangements which were made to reflect and encourage action to support this new direction.

In November and December 2000, late in the planning process, HAs were notified of the Modernisation Funds for the coming year (2000/01). The lion's share (69%) of the additional £466 million was directed at waiting lists, mental health and cancer (£276 million, £36.9 million, £9 million) (DoH 1999e). An additional £30 million was also made available to HAZ sites, although partnerships were also expected to spend this

extra money on the 'core priority areas of CHD, cancer, and mental health as part of their effort to tackle inequalities'. Funding was also 'ring-fenced' to prevent its use for other purposes. One of the HAs in the study sites also gained a small increase in revenue as a result of the weighted capitation formula being changed to better reflect local health needs (DoH 2000c). However, these additional funds were relatively small in comparison to the size of the mainstream budgets. Thus, financial resources to invest in a programme to improve health beyond the government's priorities had to come from partners' core budgets. In reality, this meant that investment in a programme beyond an illness or health service perspective was less likely to happen.

“[T]he role of health [authorities] is to deliver the health agenda and if our key priority is to reduce waiting lists and to deliver health services then any funding that might be required to go into other partnerships, if they're not delivering that health agenda, will not be the highest priority for us. And that will be the same for education, for social services.” HP Manager, HA

Even in the site where additional funds were received, following the 'health inequalities adjustment' to resource allocation, the HA steered a proportion of these monies into reducing the local acute trusts' financial deficit and waiting lists.

This section has looked at the nature and influence of hierarchical commands used by government. The next section considers the use and influence of both behavioural and output controls on the development of local partnership.

3.3 The influence of control mechanisms

In a systems model of hierarchical co-ordination, a variety of control mechanisms can be used to achieve the desired activity. By employing output and behavioural controls and monitoring performance, activity can be adjusted when it deviates from the goals set by the hierarchy. Incentives and sanctions can be used to harness the self-interested nature of actors, rewarding desired activity or punishing inappropriate pursuits. It assumes that the mechanisms of control not only reflect hierarchical goals and are measurable but that the imposition of the system itself is not detrimental to achieving those goals.

In this next section, the nature and influence of behavioural and output control mechanisms used by the government to achieve health partnership are explored. It begins by focusing on the nature of directives and guidance from central government, then the influence of its performance management system and, finally, the use of incentives and sanctions.

3.3.1 Directives and guidance

The DoH used both behavioural and output controls to direct activity in health partnerships. These were conveyed through the use of directives and guidance, instructing or directing health partnerships on matters of behaviour and output: on who to involve in partnership, the timetable for producing the HImP strategy, where to focus local policy and spend money, and service standards and targets to be achieved. HAs and their partners were influenced by the constant flow of directives and guidance emanating from the DoH. These not only shaped the way HImP and HAZ partnerships developed but also their outputs.

Instructions or directions for health partnership were communicated by the DoH, primarily through Health Service Circulars (HSCs) and Guidance (HSG). As New Labour sought to implement its programme of health service reform during 1998-99, the level of NHS guidance massively increased. Table 3.4 shows that guidance reached a level of nearly one circular per working day, a rate 5-10 times higher than that before or after this period. This guidance not only concerned the changing role of HAs and the establishment of PCGs but also the work of HImP and HAZ partnerships.

Table 3.4. Quantity of health service directives and guidance by year

Guidance	1995	1996	1997	1998	1999	2000	2001	2002
HSCs	68*	60*	54*	242	246	37	27	12

* Formerly called Health Service Guidance (HSG)

Source: <http://www.info.doh.gov.uk/doh/coin4.nsf/Circulars?ReadForm>

Acute and Community Trusts were also subject to reams of guidance and directives on issues such as managing care, the development of intermediate care and rehabilitation

and accountability as well as on funding. LAs did not escape the deluge, with commands issued in relation to the modernisation agenda and the work of ABIs.

Early guidance reflected the priorities of cancer, CHD and MH outlined in the White Paper *Saving Lives*. However, respondents from all sites asserted that the guidance did not give a clear steer on inequalities, despite this being a hierarchical goal. Indeed, there was no requirement to include this issue in second-round HImP strategies. Respondents also noted that guidance was not always clear about how different departments within organisations (i.e. the LA) should relate to one another.

Others noted that the level of detail ‘restricted’ the approach of health partnerships. For statutory partners beyond the HA, the large number of directives made participation in HImP partnerships less of a priority.

Following the appointment of the new health secretary and the shift in policy goals, the content of guidance also shifted to an emphasis on health service outputs such as waiting lists, financial balance of trusts and waiting times in A&E (June 2000). Health improvement and inequalities were accorded *de facto* a lower priority. As several respondents noted, 90% of priorities were set nationally. Funding was directed toward these priorities.

“In terms of spending, the NHS Executive is the most important [...] So at the moment they are saying spend it on waiting lists, that's what is most important to us and nothing else but that, so we spend a lot of money on waiting lists” DPH

In this way HImP partnerships were beginning to be perceived as a vehicle for meeting government priorities rather than a forum to tackle local health need innovatively.

Other forms of guidance which acted as control mechanisms of partnership were the MH and CHD NSFs, published just before and during the study period respectively. These set out a number of national standards, detailing which areas local partnerships

should focus their work on to improve the quality of care (DoH 1999b; DoH 2000b). They were specific about what local services should be provided and to what standards, leaving little scope for groups to identify and develop local priorities. The role of local health partnerships was to figure out how to deliver these priorities.

Time-tabling and timing

A key issue with respect to guidance and directives was its time-tabling and timing. This had a significant influence on the development of health partnerships across all sites, an issue recognised by nearly all interviewees (52/60 coded). HAs were locked into a centrally derived timetable to deliver the HImP strategy or spend HAZ resources - a timetable that was set by the DoH.

The late arrival of the timetable for the first HImP strategy only allowed three months for its development (the second HImP was longer at nine months). This was a short time-scale in which to negotiate and produce a multi-agency strategy. As a consequence, many respondents thought that too much time was being put into delivering the annual HImP strategy for the DoH rather than focusing on developing the partnerships themselves and delivering the agenda. As one DPH put it, it would be preferable for the HImP 'to be every three or four years and for the time in between to be filled by how NHS organisations are making progress in meeting those standards.'

Timetables were not only short but also not particularly well co-ordinated with other government departments. This placed further obstacles to working in partnership, for example, when trying to join up planning cycles, as noted above, thereby limiting the ability of the HImP to influence other relevant local strategies and resource allocation.

“Because of the different time scales that we’re in in terms of our resource allocation decisions, like in the health authority, those decisions are finalised in March, whereas in the local authority, they’re being finalised now [January], and we are at this point in the year still identifying what those priorities are for the health service, then clearly, you know, you’ve missed the boat in terms of this year’s PPR process” HImP Co-ordinator

The timing and timescale issues were compounded by the large policy agenda, each stream of which had its own time line for implementation. This drew officer time away from working on health partnership, making it more difficult to accomplish tasks within a centrally driven timescale. How actors in study sites coped with short timescales in an environment of increased time pressure on staff is explored in more detail in Chapter 4.

Similarly, HAZ partnerships were undermined by the timing and timetables laid down by central government directives. Principally, HAZs had a short 'lead-in time'. Once bids were accepted, work programmes had to be developed and funds spent within a relatively short period of time. However, the large policy agenda meant that many partners were preoccupied with other reform activities. It took half of the first year or longer (8 months) to appoint a HAZ co-ordinator in case study sites. Only then did the partnerships begin to take shape and the voluntary sector partners begin to become engaged. By this time there was increasing pressure to spend HAZ funds. As a number of HAZ actors commented, the 'cart was before the horse'. Instead of the government 'front loading' partnerships (providing funds on approval of bids), the timetable should have been structured to allow partnerships to engage fully with the voluntary sector and develop appropriate partnership structures and planning mechanisms *before* having to manage and dispense funds. This did not happen, impacting negatively on partnership outcomes.

Acceptance of guidance

The space in which HAs could lead or develop the HImP and HAZ partnerships became increasingly restrictive as guidance and directives 'rained down ever more frequently' from the centre. These were considered by statutory staff as 'imperative', 'must do's', although some complained about the 'ludicrous', excessive demands, and 'unrealistic expectations', given the short deadlines. One respondent noted that the large number of policy documents meant they were not read properly. Occasionally central guidance was reported as being subverted. For example, part of the guidance on JIPs was 'ignored' in Metrocity. On the whole, however, the statutory agencies appeared to accept central guidance and directives without much dissent, even if its content was considered questionable. Bureaucratic deference appeared to be a strong cultural norm.

“[T]hese days people accept the fact that whatever the value in terms of the public good that you get from ministerial directives, that they will happen anyway and there is not much point in fighting them. You just get on and make the best of them.” DPH

By contrast, the voluntary sector (and some LA actors) was more questioning of the need to adhere to such guidance, especially around the HAZ, and could not understand why the statutory agencies did not stand up to central government. For example, the voluntary sector in Metrocity questioned the wording of a ministerial letter which suggested that HAZs should allocate £500,000 of their funds to tackle waiting lists. After a discussion instigated by the voluntary sector, the board agreed to a compromise: the money would be used for waiting lists but it would address inequalities at the same time [Field notes].

Thus, hierarchical guidance and directives were a mechanism used to control and direct the behaviour and activities of local partnerships (policy and finance). Although specific guidance on the structure of health partnership was not given, the process and direction of partnership was actively influenced by central guidance and directives and largely accepted by statutory actors, particularly those in HAs.

3.3.2 Performance Management

The government's reform programme was not only based on partnership but also performance. Partnership between health service agencies, LAs, the voluntary sector and others with an influence on or an interest in health were to be driven by performance management (DoH 1997). To make the process more transparent, the DoH developed and consulted on a framework to evaluate performance in the NHS in six areas (DoH 1998h; Webster 2002), although none of these related to evaluating partnership *per se* and health inequalities were primarily typecast as 'fair access'.

Performance management requires the setting of output and behavioural controls – such as targets and indicators and standards or behaviours – and the monitoring of progress using audit. In the health service, long-term national health outcome targets were set for

cancer, CHD, MH and accidents. HImP partnerships were tasked with identifying appropriate targets and milestones in each of the six assessment areas for health improvement and health care. These, together with targets relating to emergency pressures, financial balance, waiting lists, primary care and mental health objectives, were quantified in Service and Financial Frameworks (SaFFs) (NHS Executive 1999b).

Similarly, LAs were also subject to performance reviews by the DoH and Audit Commission, and at the local level, performance management of services was achieved through the Best Value regime (DETR 1998). Output and behavioural standards for the NHS and LA were also set out in MH and Older People NSF.

HAs were performance-managed by the NHS Executive through the Regional Offices (ROs) (DoH 1999f). Local Performance Agreements (LPAs) negotiated between HAs and ROs focused on key issues in the National Priorities Guidance, and HAs were required to submit quarterly reports to the RO. The RO was also responsible for allocating specific grants from central government to HAs.

HAs also met with RO staff, although less frequently (i.e. twice a year), to review the HImP and other related issues. HImP and HAZ programmes both required RO approval or 'sign off'.

HA accountability to the centre, through the RO, was strong, right down to the work of the HImP sub-groups, which, in key areas such as MH, were required to report quarterly on progress in implementing the NSF (DoH 1999b). HAZ were also required to submit quarterly financial returns and twice yearly self assessments (Judge, Barnes et al. 1999). Close central monitoring was the driving force of their work with the result that 'nothing could drop off the agenda'.

Performance management actually increased over the study period both for HImP and HAZ partnerships, as the direction of the government's health policy shifted toward health services and short-term outcomes, i.e. waiting lists and A&E. These were

deemed to be more important issues by ROs, almost to the neglect of HAs' performance on health improvement.

Indeed, following the NHS Plan, performance assessment was refined and applied at the level of Trusts. The need to implement the standards set out in the NSFs was also stressed. A system of 'traffic lights' (green, amber, red) was introduced to indicate whether NHS Trusts were achieving centrally designated standards (such as cleanliness) (Webster 2002). Performance management became tightly linked to the Plan's priorities (DoH 2002b).

As a result, delivering the health service agenda and achieving the associated targets became an imperative for HAs and other NHS organisations. This pressure was expressed by CEOs across study sites, as one noted:

“[T]here are three things that get me the sack: not delivering on waiting lists, not reducing emergencies and not balancing the books...everything else is not important.” CEO, Acute Trust

Organisations had to tackle the 'non-negotiables', even if an issue was not a priority for HAs. Furthermore, for CEOs their jobs were potentially on the line.

Performance management was, therefore, a motivator and director of organisational action, resulting, for example, in a shift to more operational issues linked to key targets, such as bed blocking. As Geller (2001) notes, meeting health improvement targets carried no direct rewards, nor failure sanctions for CEOs; working in partnership on the HImP was perceived by organisations like Acute Trusts as a lesser priority to intra-organisational issues. Health improvement and investing in communities, therefore, came 'second best' to health service priorities.

“[W]e can understand the waiting lists and waiting times agenda, but it does seem to be a gross distortion of what we are actually doing. Because (Dalesville Health Authority) has missed its target, well potentially for the

third year running, it really is a big focus of the agenda. It takes a considerable amount of time and I think that has distorted, it's distorting the agenda away from some of the health issues.” CEO, PCG

This pressure to refocus work was also felt in HAZ partnerships.

“[T]he HAZ has had to change, [so] instead of just talking about poverty, inclusion, and equality in community development, it is also talking about coronary heart disease, cancer, mental health, winter pressures.” Director, Voluntary Organisation

Scrutiny of HImP partnerships by the RO reached such a level that one regional officer complained that meetings with HAs originally focused on both performance management and organisational development issues had got ‘so big that performance management had to be dealt with separately in another meeting.’ [Field notes – HDA meeting]. Heavy performance management did not make it easy for organisations to apply flexibility or to adapt to a changing and chaotic environment. The level of performance management was such that some began to question the ability of the HImP to respond to local health agendas, seeing it more as an instrument of state. As one DPH commented:

“[T]he health authority has come to a view about whether it wants to take a leading role in [...] shaping things, or whether it's going to see it [the HImP] mostly as a performance monitoring tool.”

Indeed, delivering the HImP strategy to time was increasingly seen as a performance target in itself, rather than a process.

HAZ partnerships were also subject to ‘very stringent’ performance management by ROs, even though they were still in their early, formative stage of partnership development. This was partly due to their high profile and, in the face of ministerial scepticism, to a need to show they were having an impact. Assessment involved submitting a self-assessment of progress and a high-level statement on each work stream (Bauld, Judge et al. 2000). The disbursement of funds was one measure used to

assess progress by ROs, with clear reasons expected for not spending money. Monitoring became so intense that case studies reported that it had become far greater than for core budgets.

“[P]eople have got very obsessed with how are we spending five million pounds, when each of the partner organisations is spending billions of pounds and they have less performance management on the billions than we have on five million.” Co-ordinator, HAZ

With the shift in government policy toward delivering short-term outcomes, and HAZ partnerships out of favour with the new minister, HAZs were informed at the end of the first year that they were to be ‘rain checked’ at three years to review whether funding would be continued. This served to undermine longer term planning around health inequalities. Indeed, in Dalesville, after a negative performance review by the RO to ministers, criticising the partnership for failing to spend its resources, it was advised to revise its structure and investment streams to better reflect government priorities – to the detriment of locally determined priorities.

But performance management was not unified across different government departments and therefore not across statutory agencies at a local level either, as noted earlier in Appendix L. Different performance indicators and measures were used by different government departments to monitor their respective health partnerships (HImPs and HAZs) or ABIs. Consequently, reporting to central government agencies on joint working or partnership initiatives that were co-funded resulted in duplication rather than a shared effort.

“[T]he DETR will run New Deal for Communities, the DfEE will run an Education Action Zone, expect all our organizations like health and the council and others to get involved and then run two independent monitoring and appraisal systems on both activities, both of which are running in the same area of the city. Which again spawns two lots of groups, two lots of monitoring mechanisms, two lots of accountability systems and two lots of civil servants coming at you.” Director, LA

At the local level, several HImP partnerships strived to rationalise the large and diverse range of targets on which members were required to report, identifying links and areas of overlap [Field notes]. Nevertheless, organisations beyond the NHS (in particular LAs) still performance managed their work using a separate process. Only in one site, Greenville, with well developed relations between agencies at strategic level between the HA and SS were officers making significant steps to synchronise the monitoring of joint financing and contracting systems.

Performance management by its very nature is more suited to short-term outputs or process outcomes, as these are more amenable to measurement and more directly attributable to the work of partnerships. Targets to improve health and reduce inequalities in health, on the other hand, are more ambiguous as these are inevitably long-term in nature and their achievement is difficult to directly attribute to partnership because of the influence of external factors beyond the partnership's control or knowledge. While some long-term national targets for 'health' were set in order to stimulate activity in key areas, nevertheless the focus was on health service modernisation – on waiting list targets and financial statements, with their apparently 'precise' figures (Exworthy, Berney et al. 2002). The greater suitability of these targets to a performance management system further downgraded the priority given to the health agenda.

Indeed, the pressure to identify short-term outcomes or 'early wins' and attribute them to the work of partnerships created some scepticism about government motives and some resentment.

“We shouldn't be giving into this push from government for a figure on something to say what we've done, because health improvement is a long term project.” Manager, Community Trust

Performance management was reported to have a positive role in the development of partnership in a few instances. In Greenshire, it was reported that the performance management by RO had ensured that the HA and SS had included the MH trust in its

planning process. Previously, as a provider, it had been excluded. A similar view was expressed about the inclusion of the voluntary sector in Dalesville.

Perversely, heavy performance management had galvanised HAZ partners in Dalesville, following a critical report by the RO to ministers about its development. While helpful in addressing some of the partnership's problems, the report's conclusions were perceived to be inadequate and unjust. Indignant about the accuracy and quality of the report (which was written without visiting the site), partners rallied around a sense of communal injustice. This resulted in an invigoration of group bonds and relations and purpose.

Overall, as a mechanism of control, performance management was influential on the structure, development, process and outcome of health partnership. Its increasingly heavy application, shifting focus and incoherent application across partner organisations undermined the original agenda of health partnerships and interfered with the development and processes of partnership. However, performance management had a few positive consequences in sites which helped ensure greater inclusiveness in partnerships.

3.3.3 Incentives and sanctions

Achieving the desired outputs set by the hierarchy in a systems model of control primarily relies on actors recognising and responding to organisational interests, adjusting their activity or behaviour in response to poor performance. However, as noted in Chapter 1, empirical evidence suggests actors in bureaucracies are motivated by a range of interests, some of which may not be commensurate with those of the organisation. One common approach to addressing this problem is through the use of incentives and sanctions. These seek to align organisational interests with those of actors and, in-so-doing, increase the likelihood of achieving the desired behaviours or making appropriate adjustments when performance is not achieved. In trying to direct local health partnerships, the government employed the use of incentives and sanctions. These were primarily tied into the system of performance management but not

exclusively. This section explores their use and impact on the development of health partnerships.

Incentives

The government introduced several incentives to encourage partnership and manipulate behaviour. These took two main forms: greater access to resources and greater legal freedoms to act beyond existing roles.

HAZs were supported by a specific government funding stream that provided additional resources to more or less a level specified in funding bids. The funds were to allow partnerships to develop new, innovative initiatives on health and inequalities which might then be subsumed into mainstream budgets. In particular, the granting of HAZ status provided access to resources to tackle health inequalities, and successful bids had to show evidence of partnership working. HAZ status also included £100,000 for partnership development, and allowed partnerships to bid or access other sources of funding (Innovations Fund, drugs and smoking cessation monies, NOF)(Judge, Barnes et al. 1999).

The opportunity to access additional funds came at a time when resources in the NHS were scarce. Despite New Labour's ambitious programme of reform, spending in the NHS only rose by 2% per annum in its first two years of office, as the government, for political reasons, stuck to the former Conservative government's spending plans (Klein 2001; Webster 2002). This rise was barely sufficient to cover the cost of the existing levels of service (Leach and Percy-Smith 2001b, pp.136). Furthermore, HAs and Trusts were put under greater financial pressure (Ham 1998) as the government pushed to ensure that local trusts were not in the red. In several case study sites, HAs were pressured to underwrite Acute Trust debt.

LAs were also under financial pressure, with additional funding to SS and Education departments little more than the rate of inflation (less so than for the NHS (Chancellor of the Exchequer 1998)). Increases to other LA departments were lower still, leaving district councils, in particular, feeling the pinch. As with the NHS, much of the funding

from the centre was dedicated, preventing it from being directed into other activities. As a consequence, many LA departments found themselves struggling to fulfil their duty to act in partnership. As one district council CEO complained:

“[A]ll governments are much the same, giving you all sorts of additional responsibilities and functions, and giving you no money. So [...] we're strapped for cash and we're having to make economies.”

In the general climate of resource scarcity, access to non ‘ring-fenced’ funds, such as those provided by HAZ (and other ABI) status, provided an opportunity for HAs and LAs to develop new projects without jeopardising mainstream budgets. Funds could also be used to support the development of the partnership itself (i.e. funding staff and development work).

“HAZ money is important as it pump primes peoples’ interest and engagement in addressing policies.” HAZ Chair

Flexible additional funds were, therefore, an important motivator for partnership. Indeed, over 40% of all HAs in England (41/99) applied for HAZ status in the first wave, of which eleven were accepted. Many of the failed bids applied again in the second round, including two of the case study sites.

By contrast, HImP partnerships initially received no direct funding to support their programme of work. Nor was there central funding to support the HImP process or the development of the partnership. All the government did was to change the rules governing Joint Finance, allowing sites to direct funds into this kind of activity (i.e. funding of partnership co-ordinators). On the face of it, there were no additional incentives to encourage involvement in HImP partnerships. On the other hand, HImP strategies did provide a framework to guide local commissioning and direct mainstream funding. In a resource-scarce environment, this provided an opportunity to influence local resource allocation. Although involvement was mandatory for key NHS organisations, for the LA and voluntary sector there was potentially an incentive of increased access to local resources. (The influence of additional funds and resource

allocation in motivating organisations to become involved in health partnership is considered in depth in Chapters 4 and 5.)

However, resource incentives to encourage and support health partnerships kept ‘chopping and changing’, particularly those relating to HAZ partnerships. During 1999 and 2000, the rules governing HAZ funding changed several times (see Sanctions section for details). Furthermore, additional resource streams were created and core budgets were cut in the first two years of second-wave HAZs. Cuts followed shortly after the appointment of a new Secretary of State, ostensibly in response to a £23 million under-spend in the first year (Hansard 2000) but widely associated with the change in minister and his emphasis on ensuring health services delivery. And yet an additional £30 million was allocated to HAZs for 1999/2000, again directed towards the national priorities:

“HAs are expected to spend this extra money in the core priority areas of CHD, cancer and mental health as part of their effort to tackle health inequalities.” DoH (1999e)

Additional funds linked to the HImPs were also announced, besides the Modernisation Fund. The NHS Performance Fund was set up in 2000/01 (£100 million rising to £500 million in 2003/04) (DoH 2000c), and the HImP Performance Scheme established (£10 million rising to £30 million in 2003/04) (DoH 1999f). The latter rewarded those partnerships that could demonstrate the most progress on achieving national priorities (i.e. a competitive process).

In addition to financial incentives, the government introduced legislation through the Health Act 1999 to allow local organisations greater freedom and flexibility to achieve health gain in areas of joint work (Bauld, Judge et al. 2000). This incentive allowed the HAs and SS to remove legislative barriers to joint working, enabling them to pool budgets and exchange resources (information, staff and service provision)(DETR 1998; DoH 1998c). Initially an incentive for HAZ partnerships, Sections 26-32 of the Health Act (1999) allowed all HAs to use these freedoms and flexibilities as long as they were in accordance with HImP strategies (DoH 2000d).

However, experimentation with local freedoms and flexibilities was little used in HAZ sites, including those in this study. Despite early promises from central government, HAZ partnerships themselves chose not to request or exploit opportunities for manoeuvre, often because of a lack of (or slow) response from the centre (Judge, Barnes et al. 1999; Bauld, Judge et al. 2000). Nevertheless, there was progress on integrated or joint management in all sites between some MH service providers and some exploratory discussions on older peoples' services, perhaps encouraged by the NSFs in which closer integration was identified as priority. Progress on pooled budgets was slow and identified as an issue on the agenda, still being discussed. Only in Greenshore had a joint lead commissioner between HAs and SS been appointed and proposals to exchange information with 'safe' organisations submitted to the NHS Executive. Even then, there were 'months of delays' as the plans had to be sanctioned by a national NHS board with a remit for security and confidentiality.

A third related incentive was outlined in the NHS Plan: 'earned autonomy' was available for high performing NHS Trusts (Robinson 2002). This offered both financial recognition and non-financial rewards (i.e. a relaxing of statutory requirements) to organisations and frontline staff for overall excellence and improved performance (DoH 2000a).

In addition to the incentives outlined above, the government used a number of sanctions which, combined with the performance management system, had a significant impact on health partnerships, particularly HAZ partnerships.

Sanctions

Sanctions are another means of exercising control in hierarchies, discouraging certain behaviours or punishing poor outputs monitored through performance management. A number of sanctions were outlined in the government's policy agenda. In the health service these included the threat of direct NHS Executive involvement in the running of failing organisations. Sanctions were made more explicit during the study period as the health agenda shifted towards health service delivery. The NHS Plan, for example,

outlined the imposition of Care Trusts for HAs and SS that ‘failed to establish effective joint partnerships or where inspection or joint reviews have shown that services are failing’ (DoH 2000a)⁵. NHS trusts not reaching the ‘floor’ level of acceptable performance (i.e. red) were to be put under ‘special measures’, receiving expert external advice, support and, where necessary, intervention. Additional funds (such as the Performance Fund) came with strings attached for poor performing organisations (DoH 2000a).

With regard to health partnership, one of the most significant sanctions operated by the government was the control of additional funding, particularly funding of HAZ partnerships (HIImP partnerships received little, if any, additional funding). This sanction was not explicit at the outset but imposed on HAZ partnerships at the end of their first year, following the appointment of a new Secretary of State for Health and the subsequent shift in government policy.

“[W]e’ve got central government breathing down our necks saying, you have to spend the money, slippage isn’t acceptable, you’ve got to have early results. We’re under so much pressure to spend this money.” Director, Voluntary Sector

The increased pressure on HAZs to deliver was accompanied by a change in funding rules and priorities for HAZs. These effectively operated as sanctions in two ways.

First, rules were changed to prevent funds allocated by central government from being carried over into the following financial year. Nearly all HAZs had ‘slippage’ in the first year, and initially the government agreed for funds to be carried over. In the second year, however, the new Secretary of State reneged on the former’s promise and changed the rules so funds could no longer be carried over. Any funds not spent within the financial year would be lost. HAZ partnerships were pressured to spend their money or face the sanction of losing it.

⁵The NHS Plan also noted that HAs and SS with particularly close relationships could opt to become Care Trusts, if they so wished i.e. they were also an incentive.

“The people who didn't spend quite fast enough last time round, as you know were punished for it, so there are now big incentives to spend.” Non Executive Director, HA

HAZs duly obliged, and, as a consequence, there was a significant impact on the development of partnership, interaction between partners and the quality of output, as will be shown later.

Second, the funding horizon of HAZs was halved from five/seven to three years. Funding after this period would depend on performance. HAZs deemed not to have performed or not to have been ‘effective’ would face the ‘axe’. The shortened and uncertain funding horizon meant HAZs could only plan 18 months ahead, undermining the sustainability of newly established projects, and resulting in some being ‘truncated’ (Sullivan, Judge et al. 2004) as illustrated by the comment below:

“[I] don't know what position that leaves projects in who receive three year funding initially, what are they supposed to do, go back to them and say you can't have three year funding.” HP Manager

These changes were also accompanied by a realignment of funding in line with the new priorities.

“[T]he emphasis now from the centre [is on] what are seen as health service priorities, I think that has to be our priority, otherwise the HAZ is in danger of being axed.” HImP co-ordinator

Thus, there was a strong pressure to comply with the government's new expectations, delivering ‘quick wins’ on the health service agenda. The alternative was to lose longer-term funding.

The uncertainty surrounding funding beyond three years, and the reluctance of organisations to commit their own resources beyond this period, resulted in new

projects only securing funding for two years. This further eroded the long-term aims of HAZ partnerships, to improve health and reduce health inequalities.

Fear of losing funding placed enormous pressure on HAZ partnerships to spend their allocations before the end of the first financial year. The delays in appointing HAZ co-ordinators, partly as result of the central imposition of a large policy agenda, exacerbated the pressure as HAZ partnerships struggled to take on the enormous amount of work to achieve this objective. This pressure skewed the focus of HAZ partnerships towards spending funds rather than focusing on the important processes of partnership such as developing group relationships or strategies to tackle health inequalities. The result was ‘projectitis’ as HAZs ‘dashed’ to set up projects. In one site, with approximately £4 million to spend before the funding deadline, 87 projects were set up in five months, a ‘massive amount of work’. This pressure was exacerbated by partnership being performance managed at the same time as HAZs were trying to agree projects. As one HAZ Co-ordinator commented:

“[W]e've had to do just an incredible amount of process to get that off the ground. So if you are doing that sort of process, how are you looking after your partners, how are you nurturing partnerships, how are you getting into the mainstream? It's made life really difficult.”

It also undermined the quality of projects funded, as there was less time to select projects and less time to consult with partners. In the hurry to fund projects, some were selected that would have otherwise been deemed inappropriate if there had been more time to make judgements.

“[E]verybody panics about slippage and the money being taken away, so the money gets thrown at everything.” Manager, Community Trust

It was difficult to link the rationale for projects, therefore, to HAZ strategies (Sullivan, Judge et al. 2004).

The structure and changing nature of incentives and sanction had a significant impact on health partnerships, impacting on their developmental process and their outcomes. Chapter 6 explores the nature of outcomes in more detail.

3.4 Conclusion

This chapter has looked at the nature and influence of hierarchical command and control mechanisms used by central government on the development and output of health partnerships.

The government used a number of formal command mechanisms to enact its new goals for NHS reform. These were successful in creating a variety of local strategic partnerships to improve health and reduce inequalities, building on local interest and shifting a formerly marginalised issue onto the mainstream agenda. However, undertaking such large-scale reform of the public sector resulted in a huge increase in central commands, each demanding action and diluting efforts directed towards developing partnerships. The commands (and controls) deployed also showed a lack of coherence, suggesting government was not as joined up as its message of ‘joined up government’ and whole systems thinking implied. Incoherence caused confusion and duplication, consuming resources which otherwise could have been used to develop health partnerships. Furthermore, the goals of hierarchy shifted towards health services. The command mechanisms also provided the context in which the levers of control were operated. These levers were performance management and the use of incentives and sanctions. Their intention was to drive the performance of health partnership but their application, unduly influenced by the policy shift towards health service, undermined the processes and outputs of partnership. The shift in policy resulted in a heavy application of performance management to ensure progress on achieving the new health service goals. Performance management also lacked consistency across sectors, with different partners working to different targets and requirements. These factors drew resources away from the development of partnership. Incentives, on the other hand, particularly financial ones, appeared to encourage partnership and activity on inequalities, their influence being enhanced by the general lack of resources. Changes to the rules and arrangements governing incentives, however, served to undermine the

development and quality of outcomes of partnership, particularly when linked with sanctions. Although the threat of sanctions was effective at directing activity and finance towards meeting national priorities in the health service, it drew attention away from the original purpose of health partnership of health improvement and reduction in inequalities.

Thus, health partnerships were developed in an environment of multiple, incoherent and shifting command and control mechanisms. These mechanisms interacted with one another in positive and negative ways to influence the development and function of health partnership. This influence was recorded on the structure, interaction, process and outcomes of health partnership, in general undermining their original purpose. However, this negative influence was not inherently due to the nature of the co-ordinating mechanisms (although performance management did place a resource burden on partnership), rather it was a result of their magnitude and changing structure. In particular, bureaucratic commands increased over the study period and were highly influential. They coupled negatively with the performance management system. This begs the question of whether in a less turbulent command environment, performance management, incentives and sanctions could have had a more positive effect on promoting partnership to improve health and reduce inequalities, a question that is considered in more depth in the conclusion of this thesis.

This chapter has shown the importance of the national or *outer* context on all aspects of health partnership. While this was a significant factor in all study sites, there were other horizontal influences at play which shaped relations and interactions in health partnership at a local level. These are explored in the next chapter.

Chapter 4 – Horizontal relations - balancing the costs and benefits

4.1 Introduction

This chapter explores the factors influencing the formation and maintenance of horizontal relations in health partnership. It focuses on the influence of the *inner* or local context in which HImP and HAZ partnerships were created. It draws on Resource Dependency Theory (RDT) as a framework to explore the motivational factors driving relationships and to explain the degree of involvement of local organisations in HImP and HAZ partnerships. In so doing, it seeks to address my second research question: what was the nature of local horizontal relations and what factors were perceived to be influential in driving and shaping local health partnership? This chapter begins to build the foundation of an assessment of partnership as co-ordination, collaboration or participation.

RDT is primarily focused around inter-organisational resources exchange. As HImP and HAZ partnerships were set up either to manage additional resources or influence the direction of local resource allocation in favour of health and reduction in inequalities, it was an appropriate theory to explore horizontal relations. It can also accommodate the influence of vertical relations (although these are covered in more detail in the preceding chapter).

RDT assumes that no organisation is able to generate all the resources it needs to achieve its goals (Hall 1996). Organisations, therefore, seek resources possessed by other organisations and will exchange resources to obtain those which they require as long as this does not threaten their interests or autonomy (Oliver 1991). The degree of interaction with the other organisations depends on the degree of need and the lack of alternative resources (Scharpf 1978; David and Zakus 1998). Through interaction and exchange, organisations form dependencies on one another for resources. The symmetry

or asymmetry of these dependencies, in part related to an organisation's resource base, is theorised as important in determining the degree of involvement and nature of relationships in partnership (Challis, Fuller et al. 1988). RDT assumes that actors are motivated by self-interest and are making an assessment of the value of inter-organisational interaction.

This chapter shows that respondents were making cost-benefit calculations and that these were influenced by the availability of resources and the perceived impact of partnership on organisational/actor's interests. Respondents from all sites and sectors identified a number of different issues that shaped and influenced the perceived costs and benefits. The relative weight of these 'factors' in their cost-benefit calculation appeared to be dependent on each actor's own perceptions about the relevance of the health partnership agenda to them, in turn dependent on whether they held a broad, systems view of health or a narrow 'biomedical' view. Calculations were also sensitive to the resource environment of respective organisations and the size of their resource base. Thus, actors appeared to make a complex assessment of cost-benefit of involvement in partnership.

Part I of this chapter begins by examining the perceived resource costs of partnership as well as the perceived potential benefits. It shows that actors were very aware of the costs and benefits of participating in, as well as of developing the structure and of managing the process of partnership. Part II focuses on the factors that influence actors' assessment of the potential costs of partnership, in terms of resources or threats to organisational interests, or benefits of involvement. Four factors are considered: the national agenda; local boundaries and politics; professional perspectives and organisational practices; and resource base and dependencies. The role of key individuals is also explored. These findings are then considered in relation to the assumptions of RDT, although the dynamic interaction of factors is explored in the next chapter.

Part I

In RDT no organisation is considered to have all the resources it needs. Organisations enter into exchange relations with other organisations in order to survive. This assumes actors are mindful of the resources available through exchange as well as costs associated with inter-organisational relations. Rational, self-interested actors will voluntarily establish relations where benefits are perceived to exceed costs.

The government policy agenda, through the use of command and control mechanisms, actively developed HImP partnerships. Although it placed a duty on some statutory organisations to be involved, it did not specify the structure or degree of involvement. Involvement of other organisations, like that for all partners in HAZ partnerships, was voluntary. The degree of involvement, according to RDT, is dependent on their assessment of resource costs and benefits associated with health partnership. Were such considerations on the minds of actors, including those with a duty to be involved? And what resources were being considered? This Part of Chapter 4 begins by noting that respondents were almost universally aware of resources involved in partnership. It then identifies some of the commonly identified costs associated with partnership as well as the potential benefits of involvement. Finally, it reflects on the assumptions of RDT.

4.2 Resource implications of partnership

There was almost universal recognition amongst interviewees from all sectors and study sites that engaging in partnership had resource implications for their organisation. Resources were required not only to get involved or manage partnership but in some instances for exchange or use in accomplishing the partnership's agenda. Types of resource included human (such as officer time), finance and information. Partnership needed resources to develop. Aside from those required to set up the structural systems and governance mechanisms (such as monitoring and evaluation structures), it required considerable resources for involving or consulting the voluntary sector or community. The next sections consider the costs in more detail.

4.2.1 Resource costs of participating in partnership

Many of the resources used, especially time, and more intangible resources such as energy and effort, were hidden, and organisations with small resource bases were particularly sensitive to these, as we shall see later. One of the greatest burdens was officer time and officer numbers involved.

Partnership is a time consuming process

Respondents from all sites and sectors acknowledged that partnership required an enormous amount of time to make progress, both in its cross-sectional and longitudinal development. Working in partnership was a slow developmental process. The investment of time was particularly intense in the beginning when the partnership was being set up and partners were trying to understand the agenda, exploring what to do, putting together and negotiating plans, but also when it was up and running. Getting people together, talking about the concept of the HImP, assessing health problems and finding solutions took a lot of time. Time also had to be dedicated to *maintaining* the process of partnership, to building good relations between partners.

“[P]artnerships take time to develop and put in place and you have to allow that time and that period to let that happen, otherwise you actually do breed distrust later on.” Director, VO

Time was needed to engage partners, to ensure they were listened to and heard, to create enthusiasm and maintain a vision. Changing peoples’ behaviour or approach to work took time.

This was often under-estimated, the process taking ‘longer than you think’. Indeed, lack of investment of time was considered to undermine the process of partnership and the quality of decision-making.

Human resources

Partnership also had significant human resource cost not only in terms of officer time (used up in the longitudinal development of partnership) but also officer numbers (for its cross-sectional development)

Sending organisational representatives to attend partnership meetings was time consuming for officers, especially as the process of decision-making tended to be slower and more drawn out than conventional mechanisms. Accomplishing the partnership agenda could also greatly increase the workload of already busy officers. Strategic health partnerships, such as HAZ and HImPs, specifically involved managers with wide-ranging roles and commitments, and therefore with very little additional time to give.

Partnership had the potential to involve a large number of staff. This was a consequence of the broad health agenda that HAZ and HImP partnerships were set up to tackle – the large number of programme groups, reflecting the large number of health and social care priorities set by government. Many partnerships had between 10-20 priority areas, with up to 60 sub-groups. The sheer number of groups meant that a large number of staff was involved, although some key individuals were involved in more than one group. Indeed, as we shall see later, many organisations were struggling to place staff on appropriate groups.

Staff time and other resources were also required to administer and manage the partnership, especially those organisations involved in co-ordinating or leading the process. This included the cost of staff time in writing up minutes and sending out papers but also more hidden resource costs such as telephone and e-mail costs, faxing, photocopying of papers, travel costs for partners (especially an issue for the voluntary sector) and host costs. The large size of the health partnerships magnified this cost considerably.

Thus, it was widely recognised across all sites and sectors that not only was the initial resource cost of establishing partnership high and immediate but there was also a heavy resource cost associated with on-going engagement in health partnership.

“[I]t’s a big process, and for it to work, there needs to be that commitment of resources so that it, you know, works in a good way.” CEO, CHC

Partnership could have direct financial implications for participating organisations, with money being used to support the process of partnership or its programmes. These potential costs could have a significant impact on involvement and relations in partnership, as will be seen later.

However, partnership also had the potential to deliver resource benefit, the term ‘resource’ being considered in its widest sense.

4.2.2 Resource benefits of participating in partnership

The benefits of health partnership not only included potential tangible benefits such as access or influence over resources (additional or core) but also less tangible benefits.

Additional resources were primarily available for HAZ partnerships in terms of HAZ funds. Partnerships could use these to develop creative and innovative projects and services as well as to support the partnership itself. Meanwhile, there were no specific funds to support HImP partnerships, except small, ad hoc additional monies ring-fenced for specific health service developments (see Chapter 3). One site, however, did allocate former JF monies to its HImP partnership, despite no obligation.

Additional money was perceived to be about adding value, allowing organisations to develop projects or services in new ways. In Greenshire, for example, additional monies

to the HImP were reported to have enabled the MH and OP partnership groups to take a broader and more preventative perspective.

Financial resources were also provided by central government via SS through the carers, partnership or prevention grants. The availability of additional resources is outlined in Table 4.1.

Table 4.1. Availability of additional resources in each case study site for 1999/2000

Additional monies	HAZ	HImP
Greenshire	N/A	£2.1 million (Joint Finance ¹)
Middleton	N/A	£0.97million (Joint Finance ¹) £1.3 million (Health Inequality adjustment)
Metrocity	£0.80 ² million (part of £6.1 million over 3 years)	£1.7 million (Joint Finance ¹)
Dalesville	£0.92 ² million (£5.3 million over 3 years)	£1.4million (Joint Finance ¹) plus other monies

¹Figures for 1999/00 from HSC. After April 2000 Joint Finance allocations were incorporated into the unified resource allocation and not distinguished as a separate item.

²HAZ funding. Overall there was £30 million for HAZ for 1999/2000 (HSC 205/98). In December 1999, an extra £60 million for HAZs was announced (HSC 243/99).

Furthermore, resources were seen as a facilitator for accessing more money like European funds, even though putting together such bids was resource-intensive in itself. Working with new sectors (such as the voluntary sector) also increased knowledge and awareness about the availability of resources in the wider system.

Respondents also identified a number of benefits that related to *relationships* between partners, the *process* of partnership and process *outcomes* (even though some respondents found these more abstract benefits of partnership more difficult to assess).

Partnership did not only result in improved relations between organisations but also increased awareness of other organisations in the wider environment. Partnership, through its structure, had brought together and developed relations between organisations that hitherto were unaware of each other's existence, raising an organisation's profile.

Partnership increased mutual understanding of partners, their approaches to work and the constraints they faced. It helped individuals appreciate what was driving people in other organisations and, in some cases, had opened their HA's eyes as to what could be done in terms of the poverty agenda in other organisations. Increased awareness of how different systems worked was important when tackling 'hard issues', enabling partners to be clear about each other's role and responsibilities and helping to avoid misunderstanding.

In Greenshire, partners developed a project to increase their access to NHS information. The development of joint planning structures also facilitated partners' access to sensitive financial information. This in turn, through the process of partnership, had brought changes in attitudes and understanding of other actors and organisations, changing perspectives and scope of work, enabling new solutions to traditional problems. Similarly, organisations working in partnership were forced to think about winter pressures and intermediate care in wider terms than just service provision, leading to better services.

Partnership improved co-ordination of services between agencies and created efficiencies. It also enabled organisations to identify issues in common, referring contacts with similar interests to one another. Pulling work together into one place, despite having the potential to increase officer workload, could reduce the number of meetings, saving work. Indeed, some respondents argued that using partnership to allocate resources was more efficient than deploying resources in isolation. In this way,

it could build on existing HA and SS services rather than duplicating or developing new ones in isolation.

Generally, there was an expectation that the work of health partnerships would be translated into activity at a strategic level beyond talk of policy ideas or theoretical issues. However, there was widespread recognition amongst respondents that many of the benefits of partnership would take at least 2 to 3 years to be realised.

“You accept that partnership working is difficult at first, takes time, but eventually will have pay-offs for your organisation, and more importantly, the people that you’re serving.” Manager, PCG

For some officers, benefits were also contingent on the early investment of resources (time, money and effort) in partnership. For partnership to enter a productive phase, partners had to invest time talking to one another and sharing ideas. Several interviewees commented, therefore, that it was still too early to assess whether partnership was delivering benefits.

However, not everyone saw value in partnership. It was a challenge for some officers to recognise that letting go of their ‘old role’ and working collectively could bring benefits. Others were unsure whether the benefits would filter down into the organisation. Thus, although there were some direct, tangible benefits available for participation in health partnerships in terms of access to resources, other resource benefits were more abstract and dependent on the process of partnership.

4.2.3 Summary of resource costs and benefits of partnership

Establishing, maintaining and developing partnership was very resource-consuming. An array of resource costs were mentioned by almost all interviewees, from all sites and sectors and recognised as immediate and on-going. The resource benefits of partnership could be concrete where additional funds were available or less tangible where they

related to improved inter-organisational relationships, awareness and perspective and potential outcomes. There was differing awareness of the more intangible benefits. Furthermore, there was widespread recognition that the benefits of partnership were contingent on some initial resource investment and would also take time to realise. In HImP partnerships at least, the more abstract resource benefits of partnership were easily overshadowed by the immediate and direct costs of involvement.

Part II

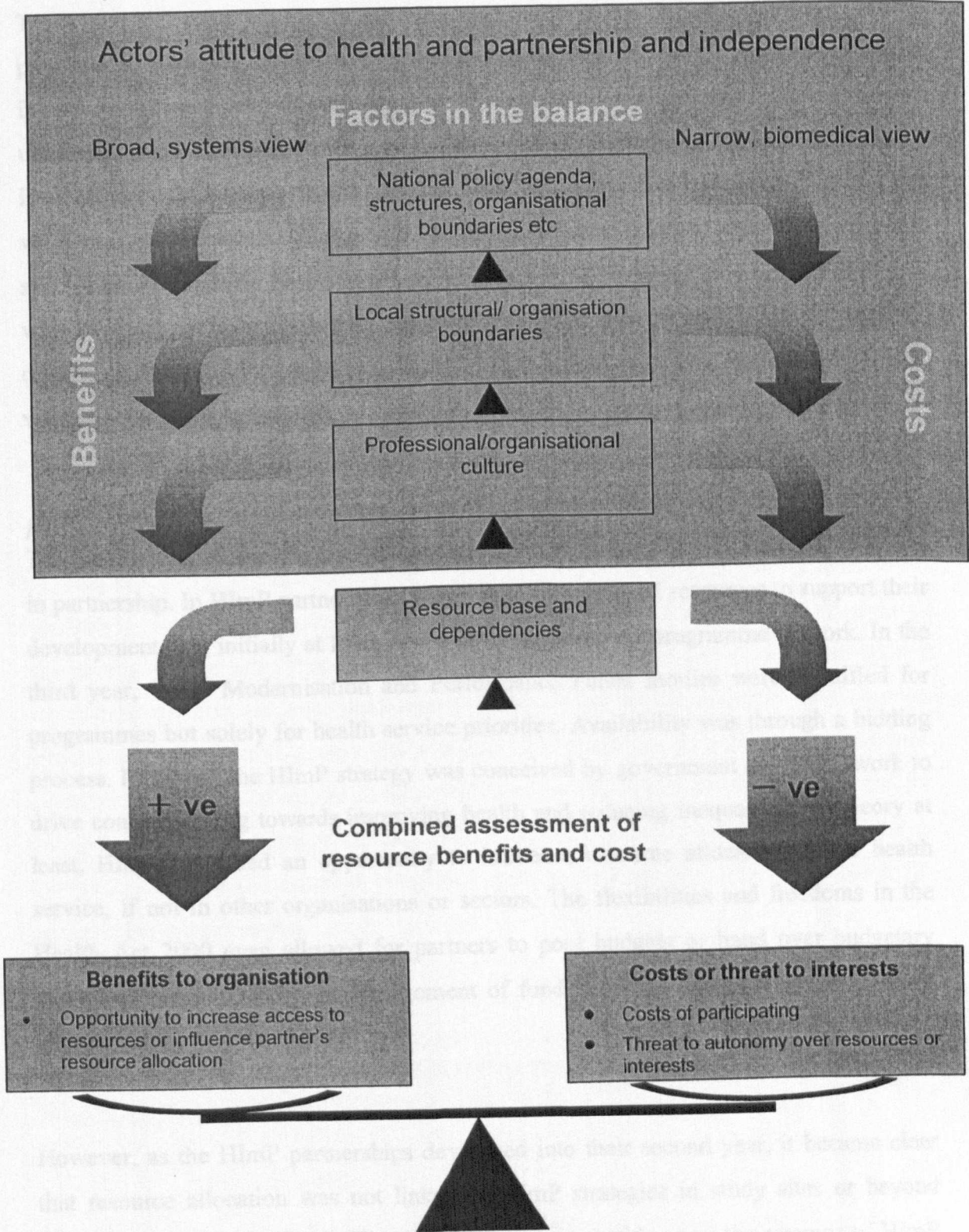
RDT argues that organisations seek resources they need from other organisations as long as it does not threaten their interests. Actors are assumed to calculate whether entry into partnership will increase access to resources or threaten their interests. The potential benefits of partnership have to be weighed up against the costs of involvement, the implication being that where benefits are perceived to outweigh costs, actors will engage in partnership, as discussed in Chapter 1. However, this trade-off was not straightforward. Respondents from all sectors and sites identified a number of factors that impinged on their assessment of the potential resource benefits of health partnership as well as potential costs or threats to organisational interests. This part of the chapter explores how these factors influenced perceptions of benefits and costs of partnership. It identifies five factors that appear to be influential: national policy agenda, local structures and organisational boundaries, professional and organisational culture, key individuals, and resource base and dependencies. These factors are presented in Figure 4.1, which also shows how they combined to influence an actor's decision over whether or not to get involved in partnership. How factors combined is explored in depth in Chapter 5.

4.3 National policy agenda and reforms, structures and boundaries

This section explores how the national agenda and national structures were influential in shaping actors' perceptions about the resource costs or their interest in participating in health partnership.

Voluntary participation
 The government's reforms not only promoted health reform but also encouraged a shift in partnership.

Figure 4.1. Factors that shape actors' assessment of resource costs and benefits of partnership, influencing their degree of involvement in partnership.



Mandatory participation

The government's reforms not only promoted health partnership but also placed a duty on NHS organisations to work in partnership. The Health Act 1999 mandated HAs, Trusts and PCGs to work in partnership, primarily in the HImP, a strategic health partnership. However, although the government signalled in policy documents that it intended to place a duty of partnership on LAs, it did not become a legal requirement until the Local Government Act was approved by parliament in July 2000. The involvement of statutory organisations such as CHCs, probation, universities etc and the voluntary sector was not obligatory. With the exception of HAs, the government did not specify how and where partners should be involved in HImP partnerships. Thus, there was wide scope for variation in terms of the level and degree of engagement by organisations in HImP partnerships. Involvement in HAZ partnerships, meanwhile, was voluntary for all organisations.

Resource benefits of participation

The national policy agenda also determined some of the potential benefits of engaging in partnership. In HImP partnerships, there were no additional resources to support their development and, initially at least, no funds to support their programme of work. In the third year, 'new' Modernisation and Performance Funds monies were identified for programmes but solely for health service priorities. Availability was through a bidding process. However, the HImP strategy was conceived by government as a framework to drive commissioning towards improving health and reducing inequalities. In theory at least, HImPs provided an opportunity to influence resource allocation in the health service, if not in other organisations or sectors. The flexibilities and freedoms in the Health Act 2000 even allowed for partners to pool budgets or hand over budgetary control of commissioning or management of funds to other organisations in areas of joint work.

However, as the HImP partnerships developed into their second year, it became clear that resource allocation was not linked to HImP strategies in study sites or beyond [Field Notes – HDA]. The SaFF and JIP work were outside or on the margins of HImP partnerships.

The influence of HImP partnerships over partner organisations' resources was also diminished by the lack of synchronicity between the SaFF and HImP planning processes as well as with other organisational process, as noted in Chapter 3. Thus, the HImP provided limited opportunity to access extra resources or influence allocation of health service resources or those of other organisations.

While engagement in HImP partnerships had the potential to consume organisational resources, as noted in Part I, there were no additional resources to support these partnerships. Although moving JF into mainstream budgets enabled these monies to be used to support voluntary sector involvement in HImP partnerships and, in some sites, fund a co-ordinator, these were not 'new' resources. Furthermore, they were considered insufficient by some HAs, which resorted to asking HImP partners for more money.

By contrast, HAZ partnerships were a source of additional resources. Funds were available to support the partnership process and fund creative and innovative projects and services. They could not only help offset some of the cost of developing and maintaining partnership but could also provide access to flexible (non ring-fenced) resources. In a resource-scarce environment, this could be considered a significant incentive to participate. Indeed, it was sufficient for some partners to come together in the first place to prepare joint bids to access these funds, mainly HAs and LAs. However, the resource costs of participating in partnership still had to be borne by participating organisations.

Access to additional resources – an incentive to engage?

The availability of additional resources did provide an incentive for respondents from all sectors to engage in HAZ and HImP partnerships.

“If we hadn't have had money then I don't know, it's hard to know how attractive we [HAZ and the health agenda] might have been seen by the local authority.” Assistant Director, Older People's Service, HA

Additional monies were attractive to partners because they allowed organisations to ‘pump prime’ or develop new, innovative projects, change programme delivery or fast-track existing policy initiatives.

“[W]hat the HAZ has done is it helps keep it [health partnership/joint working] on the agenda and it brings some resources to assist us.” Assistant Director, LA

Flexible additional resources were particularly attractive (i.e. non ring-fenced). Not only could they be used to employ a partnership co-ordinator and support the involvement of the voluntary sector but they could also act as a ‘liberator’, enabling organisations to address issues in new ways, without worrying about financial boundaries (i.e. between health or social services). Indeed, the infusion of HAZ money into the CHD group in Metrocity, it was reported, had provided impetus to a flagging NSF group.

On the other hand, some organisations did not see the point of engaging in partnership that did not have additional resources attached.

“If we don’t have a small amount of money to do things in partnership, people quite easily get disenchanted and see it as just a talking shop. Very cynical, ‘what impact are we making?’...‘we never get to change anything?’” Head of HP, LA

For some actors, however, the additional funds (including HAZ monies), although welcome, were considered too small to impact significantly on the public health (PH) agenda.

“[T]his is a huge agenda and it needs proper resourcing at a corporate strategic level in order to make it happen.” Assistant Director, LA

Funds were ‘small beer’, representing only a tiny fraction of large statutory organisations’ budgets (see Table 4.2). The relatively small funding contributed to the partnerships repackaging and recycling old initiatives rather than taking more radical approaches.

Table 4.2. Additional funding (£ million) for tackling health inequalities (HAZ funding and special allocations) as a percentage of total budget by site for 2001/02.

	Middleton	Dalesville	Greenshire	Metrocity
Budget (with adjustments)	239	365	464	391
Health Inequalities allocations (HAZ/specific allocations)	1.1 ¹	3.4 ²	0	3.2 ²
HAs % of budget	0.4%	0.9%	0	0.8%

¹ Non HAZ adjustment for deprived areas

² HAZ funding

Furthermore, additional funds were short-term (approximately 3 years). This undermined the use of funds supporting VS involvement or service developments (beyond capital purchases) as the lack of continuity in funding posed a threat to the stability of mainstream budgets.

“[S]ome of it’s not all that useful because it’s not recurrent money and very difficult to spend without considering the revenue implications in the long term, and that’s a real difficulty.” Assistant DPH

Additional resources could also come with ‘red tape’ attached. As noted in Chapter 3, HAZ monies generated additional bureaucracy as partnerships were required to submit detailed monitoring and evaluation statements on resource expenditure to the centre. Heavy central control requirements could also undermine the quality of decisions as partnerships were under pressure to spend funds. Under such pressure, decisions about allocation could disproportionately occupy the agenda as agencies vied to secure their preferences, distracting the partnership away from its purpose. Thus, the attractiveness

of additional resources could be reduced by the size and recurrence of funds and the conditions and degree of central control attached to them.

Cost of partnership in a resource-scarce environment

As noted in Chapter 3, by adhering to the previous administration's spending plans, the government maintained a resource-scarce environment for statutory agencies (and for organisations financially dependent on them). Furthermore, government pressure on the NHS and LAs to correct outstanding financial deficits increased pressure on budgets. HAs and LAs were operating within tight financial limits or with 'massive budget problems'.

“[W]e [the HA] were working in a period where we were facing significant financial constraints, and so the message was, ‘well there is no development at all’, and we may even have to cut back existing services.” Director of Strategy and Performance Management, HA

The government also set the level of management and administration resources available to support the development of PCGs. These were widely regarded as insufficient (Wright 2001). NHS Trusts had also seen resources to support management cut by government. Thus, human resources were also under pressure in these organisations.

However, at the same time as creating a resource-scarce environment, the government was pushing the implementation of its large policy reforms. It set tight deadlines for implementation and put pressure on the NHS and LAs to deliver the modernisation agenda, including meeting health service process targets.

“The principal problem has been the capacity of the organisation to support the process in the timescale that's available.” ADPH

Organisations were not only expected to implement reforms in their own organisations but also to work in partnership to deliver a local health strategy. This was also in addition to existing duties required of statutory organisations.

There were conflicting resource demands and pressures on HA, LA, Trusts and PCGs, between those required for partnership and those required to achieve wider organisational reforms. As a consequence, partners were forced not only to prioritise how much human resource they gave to partnership (officer numbers and time) but also which activities they were to focus on in partnership.

“I’d like to be able to be more involved. But there’s only so many hours in a day, and there’s only so many things you can actually fit.” Manager, CHC

Officers, for example, had to weigh up the time and resource costs of attending meetings against the benefits of participating.

The lack of resources also impacted on the ability of organisations to exchange funds.

“[T]he budgetary constraints that we’ve got [LA], partly of our own making and partly of government’s making, doesn’t allow easy movement of money from one organisation to another, and where it happens is quite unusual.”
Neighbourhood Director, LA

Influence of performance management and must dos

To ensure delivery of its agenda, the government imposed a performance management regime on statutory organisations. Poor performance carried the threat of loss of resources or organisational autonomy.

As noted in Chapter 3, performance management was initially focused on the whole reform agenda. However at the beginning of the study the focus in the NHS began to shift towards emphasising the delivery of health service priorities and modernisation

agenda. Close monitoring and tight control over additional resources created insularity in statutory organisations. They became increasingly inward looking, concerned with getting on with their own agenda, rather than accomplishing an inter-organisational agenda.

For the NHS, health service priorities were around waiting lists, winter pressures and A&E, particularly for Trusts, while LAs were ‘dancing to a different tune’. Besides their duties to produce various community plans, LAs were being pressured by the DETR to implement the Best Value regime and other modernisation reforms.

Under such pressures, different organisations had different perceptions about the importance of the health partnership agenda. Furthermore, as the nature of the agenda was about long-term health improvement, individuals tended to respond to more immediate concerns such as the reforms related to modernisation. With the exception of PH departments, health partnership was beginning to play second fiddle to other organisational reforms.

“[W]hen resources are tight, people move back into meeting their own bottom lines, and the HImP is only a bottom line really for the Health Authority.” DPH

In striving to fulfil these reforms, limited human and financial resources were directed into other activities besides health partnerships, undermining their development. As the Head of Planning in an Acute Trust noted:

“HImP-related matters [...] I have to say, that it is not at the top of my list of priorities [...] and some of the softer stuff around developing relationships probably suffers because we view that we’ve got other priorities that are more pressing.”

Thus, HImP partnerships were bound by a ‘cost-time quality’, in which time and human resource considerations were driving the level of involvement.

Internal re-organisation

Another factor that made organisations very internally focused was internal re-organisation. Such reforms distracted some organisations' attention and further limited the resources available for partnership.

A number of LA departments in all sites were undergoing or had just undergone re-organisation, primarily SS and housing. These were either as a direct consequence of the on-going resource-scarce environment, or national and local (political) pressures for financial propriety, poor service performance (children's services, Middleton) or government policy (i.e. on devolving housing services).

“[S]ocial services is overspent and it has to save money.” Non-Executive Director, VO

“We’ve actually, because of financial problems, reorganised this section.” Director of SS

This section has shown how the national context set the parameters in which the resource implications of engaging in partnership were assessed. National policy set the resources that were available for those entering into partnership as well as influencing the environment in which the costs of engaging in partnership were weighed up. Some flexible funding was available as an incentive to get involved in partnership, although this became less flexible as the government shifted towards a health service-orientated agenda. The creation of strategic health partnerships also presented a potential opportunity to influence local resource allocation. However, the government also created a policy agenda in which statutory organisations faced significant, multiple reforms, with limited resources to undertake the reforms. This placed competing demands on resources. The government also used performance management to drive change, with potentially serious sanctions for poor performing organisations. This combination of national constraints significantly influenced actors' interpretation of the costs associated with engaging in partnership in comparison with the costs of not fulfilling other pressing demands. As it will be shown in Chapter 5, the degree of

organisational involvement in partnership (and behaviour) appeared to reflect these calculative assessments of the benefits and costs of partnership. However, there were other factors at play that appeared to impinge on actors' assessment of the resource implications of partnership. These were related to the local rather than national context.

4.3.1 Local structures, organisational boundaries and local politics

This section reviews the influence of local organisational structures and boundaries and local politics on the degree of engagement in health partnership. It explores how these factors influenced the assessment of the potential costs and benefits of partnership and the impact on organisational involvement in health partnership, particularly for local authorities, where politics, politicians and resources have a key role.

First this section considers how local structures and boundaries define or influence organisational interests. Then it considers how these interests may or may not be represented in strategic health partnership. Finally, it explores how political interests or resources may be threatened by partnership, as it often requires some loss of organisational autonomy and control over resources.

Local structural and boundaries shape organisational interests

Interviewees from all four sites recognised that communities or locations within each site had different identities. These identities reflected different socio-economic and demographic characteristics and were particularly diverse in rural sites. Rural sites (and urban sites) had a mixture of rural and urban communities with varying degrees of affluence and poverty. Some were based on traditional but declining manufacturing industries (Dalesville) whilst others were based around market towns or agriculture (Greenshire). Different areas also had shrinking or stable populations, and different ethnic or age structures. As a consequence, there were very different social and economic problems within short distances and correspondingly different issues or problems which impacted on health within districts (such as bad housing stock, poor educational attainment, low wages).

“What the problems are in [Greenshire Town] a fairly compact urban area are totally different from out in the rural areas.” CEO, LA

Thus, within a health district there could be different health problems located within a particular organisational boundary. Organisations could have very different approaches to their work and consequently very different agendas or interests.

“What we had was in effect four different local authority situations, if you like, and significantly different communities, the interests of [these authorities] are very different.” CEO, HA

The most common organisational boundary to create difficulty or tension was local government, although differing PCG, Trust, Police and the voluntary sector boundaries could all be significant. In rural sites in particular, organisations were more likely to represent divergent interests as the LA structure and the communities represented were more fragmented (rural study sites contained a mixture of unitary, district and county councils) while the number of NHS organisations tended to be greater to ensure access over larger areas. By contrast, coterminous authorities could unite the interests of heterogeneous communities under one organisational roof.

“We’ve got coterminosity between the two organisations [HA and LA]. That’s a huge advantage compared to those where health authorities try to deal with five different councils, all with their own separate agendas and political leanings.” Manager, Environmental Health

However, as will be shown later, differing organisational interests could be overcome by key individuals or by strong political leadership.

Strategic and local priorities

Strategic health partnerships such as the HImP were set up to take a district, even regional, view of health issues or problems. However, apart from some coterminous

locations, health partnerships inevitably involved more than one LA and many NHS and voluntary sector organisations, each with their own local priorities or issues.

While some issues or problems were suited to consideration at an area-wide level (such as learning and physical disabilities services and some acute services, where numbers were relatively small), others were better considered at a local level (i.e. older peoples' services). Furthermore, some issues were specific to a locale and not identified in an area-wide strategy. Indeed, the more LA and PCG boundaries, the more divergent local and strategic agendas became.

Dealing with many different vested interests influenced the structural design of partnership (especially HImPs) and the approach to the health agenda. How different local and area-wide or strategic priorities were identified and accommodated in health partnership, particularly in rural sites where organisations were representing very different agendas, also had important implications for the degree of organisational involvement in partnership. Organisations whose local interests were not represented on the strategic agenda found it more difficult to justify their involvement to constituents. The benefit of involvement was less easy to justify while the costs of involvement were still present.

In Dalesville, for example, a pan-LA health and social care partnership was set to improve cross boundary working and moderate the influence of multiple interests. To tackle the wider determinants, separate health partnerships were established in each of the three LA areas so as to enable a greater locality focus and encourage greater senior officer engagement.

Local politics and politicians

For some organisations, representing the issues and interests of their local populations or communities was particularly important. This was the case for local authorities (and to a lesser degree voluntary organisations). Unlike HAs and other NHS partners, LAs are not just organisational but political systems. LA members are elected to represent

the interests of their communities and have the power to set policy and sanction activity and resource allocation in their organisation. Members are also accountable to their communities for the LA's actions.

There was widespread recognition by interviewees that local politics and politicians were an important element when considering LA involvement in partnership. The support of councillors was considered crucial by many LA officers, if a partnership was to make decisions on strategic development of services or decisions with financial implications.

“[S]witching mainstream resources into health inequalities work...there needs to be a political will to make that happen within the council because it's the councillors quite rightly who decide where the money goes.”
Neighbourhood Director, LA

The commitment of politicians to the health partnership agenda was important in ensuring organisational commitment and, therefore, officer involvement.

“[T]he members have to sign up to be in a HImP and, if they've decided they didn't want to be in a HImP, you know, we're not essentially a partner.” Policy Officer, LA

This was recognised in all case study sites and, although councillors were only directly involved in one HAZ partnership (Metrocity), their indirect involvement was the subject of discussions in other sites.

The political commitment of councillors was in part dependent on either their or their party's views on health and partnership. The political 'colour' of a LA and their sympathy or antipathy towards the national government and its policies could influence the degree of involvement in and commitment to the health partnership agenda, although these affiliations did not always follow party lines.

Changing political fortunes could also be disruptive to officer involvement as an incoming party's manifesto may have different views on or significant implications for involvement in health partnership. This was the case in three of the study sites.

“[W]e’ve now got a leader of the council, who is no friend of ours, or hasn’t been in the past, he’s been leader of the council since the beginning of May, and every message he’s given out is very positive about wanting to build links, and working in partnership with the [voluntary] sector. And that’s an incredible sea change from him, and probably an incredible sea change from a lot of other councillors who are now involved in [the] management of the city councils” Director, VO

In Metrocity, for example, a pledge to reduce council tax by the incoming party not only had resource implications for the LA but also for organisations dependent on its largesse (i.e. the voluntary sector). This increased both sectors’ sensitivity to the costs of involvement. Conversely, a party or politician in favour of partnership could increase tolerance of the costs.

Since rural study sites had a greater number of LAs, they were more likely to have differing political perspectives as well as to undergo political change. Where perspectives were antagonistic, this could create tension as differences in interests had to be resolved for partnership to progress. Moreover, it was not just whether councillors were in favour of health partnership that influenced their involvement. Councillors had different priorities and pressures, apart from committing their organisations to engage in health partnership. These included ensuring the LA fulfilled its statutory duties but also responding to the concerns of their constituents.

Organisational engagement in health partnership could threaten local political interests (individual or organisational) in a number of ways. Three in particular emerged from the analysis of interviews. These relate to the loss of organisational autonomy; political ‘bottom lines’ or manifesto commitments, democratic role and control over resources.

Bottom lines

First, it was in the interests of all councillors to get re-elected. Anything that threatened this 'bottom line' could be politically difficult to support. Unfulfilled pledges or activity that diverted organisational resources away from manifesto commitments could be untenable.

“[There’s more votes in dustbins than in elderly people services, and even less in the HImP. There’s no votes in it for city councillors...the new leader of the council got in on the promise to clean up the city.]” CEO, Acute Trust

Furthermore, the issues tackled in health partnership could be politically unpopular, such as the opening of a new mental health facility or the repositioning or re-organisation of an Acute Trust or its services, as witnessed in two of the case study sites.

“[The] policy agenda is set by our members, which may be at variance with partner members’ agenda...working through that obviously creates major problems. [The] community hospitals issue, over the past two or three years, I think has been a major problem.” Director, SS

Democratic role

Second, the presence of a health partnership which actively engaged the voluntary sector threatened some councillors who feared it might undermine their democratic role as representatives of the community. Indeed, in two sites councillors had obstructed voluntary sector or community development projects, believing it was the role of members to be the voice of local people. In Dalesville:

“W]e had begun to do some work around community development. As it got started there was a big hoo-ha by the councillors in that area, because they felt that the [...] community development work was beginning to take over the job of a councillor in that patch. What that actually meant was that we couldn't get that piece of work off the ground at all.” DPH

In Metrocity there was tension between the councillors and the community representatives group on the HAZ partnership and the legitimacy of both parties to represent the community was debated.

“[I]f there’s a sticking point and this happened in the earliest days of the [community representative’s] group more so, it would be local councillors saying, we represent the community, where’s your democratic accountability?” Director, VO

Resource control – autonomy and opportunity costs

Third, engaging in partnership was an opportunity resource cost. Involvement required the use and commitment of resources such as officer time and administration costs (at a minimum). However, some councillors had different priorities for the core budgets, which did not necessarily relate to the health agenda. If councillors were not ‘signed up’ to health partnership, it could be difficult for them to commit organisational resources away from other areas to support its development.

Even in LAs where councillors were on the whole supportive of the health partnership, financial concerns about the resources required for active participation (officer time) or overall levels of budgets could compromise the degree of their engagement.

“[W]e’ve actually now got a local authority that is in some considerable financial issues, so we’re in those sorts of situations, they won’t easily be coming to their table to pool budgets, because they’ve got to manage their own financial problems through.” DPH

Involvement in partnership was also hindered by fears about the loss of control over resources, even though it might improve the strategic planning across organisations and reduce duplication. Councillors found it difficult to work in partnership, particularly if it involved sharing budgets and using new freedoms.

“[Y]ou’re not likely to lose the Community Care Plan, because councillors aren’t going to want to relinquish the power and control they have over

spending within social services, and so, to sort of put all that into the HImP, which appears to be a health authority-owned strategy, is probably a step too far for many councillors.” Director, VO

In LAs under financial pressure (in most sites), councillors were more prone to prioritise work on core activities rather than those of partnership, even if they were supportive of the health partnership agenda and could see its benefits. A number of officers noted that the cost of involvement had become an increasing concern; too many resources were going into meetings without evidence of any outcome.

This section has shown how local structures and boundaries as well as local politics can sensitise officers or councillors to the costs of health partnership, especially when involvement is not perceived to be in their or their organisation’s interest. In rural sites, many strategic issues were not considered to be relevant to local organisations and their constituents. In this scenario, the benefits of engaging in partnership are less obvious. LAs in particular were sensitive to the cost of partnership, as these organisations were at the behest of local politicians and their interests. Health partnership could involve the loss of financial autonomy, their role as elected representatives and, ultimately, of their power. This was a price too high to bear for some politicians. For other politicians with a sympathetic view toward health partnership, this was less of a concern as the benefits were more readily understood. The role of an actor’s attitude to, or understanding of health and partnership when making an assessment of the costs and benefits of health partnership is considered next.

4.3.2 Attitude to health and partnership

This section examines the attitudes and perspectives of individuals and organisations towards health and partnership. It explores how an actor’s perception of health and partnership was fundamental to the calculus of resource benefits or costs/threats to interests posed by health partnership. An individual’s attitude framed how the other factors identified in Figure 4.1 were interpreted or weighted and, therefore, could alter the balance of the calculation in favour or against involvement.

Attitudes to health and partnership could be loosely categorised into two camps. The broad, systems view of health and partnership and the narrow, biomedical self-interested perspective.

Systems versus a narrow view of health

The systems view recognised health in its broadest sense as physical, mental and social well-being and not just the absence of disease. In this model, health was determined by a multitude of interconnected social factors that went beyond the health system.

“[The] major determinants of health actually aren't to do with medicine, but are to do with other things.” Director, VO

As such the task of improving health requires actors to recognise the contribution other organisations can make and that actions by other organisations can have positive or negative consequences for health.

“[P]eople often have complex needs and they transcend organisational boundaries and how are we going to address that, because we're [...] trying to improve the health of those individuals, and we have to have a perspective that enables us to do that.” HImP Co-ordinator

Actors with this perspective see solutions to health problems as beyond their own organisation and in relation to the population. They are also more likely to be considered as altruistic – acting beyond the call of duty, for the general good. This view sits naturally with partnership as a way of working. Partnership can be considered a mechanism for bringing different actors or stakeholders together to tackle difficult, complex and inter-related social problems (Gray 1989).

Indeed, government literature on partnership emphasised this perspective through the promotion of ‘Whole Systems Thinking’ as a tool to implement its policy agenda. Health partnership guidance also emphasised the need to ensure that ‘all stakeholders

are actively engaged at key stages in the annual planning, monitoring and delivery processes' (DoH 1999f).

By contrast, the narrow or 'biomedical model' sees health as the presence of disease or illness. Social factors are not considered as relevant or as important as those relating to the individual, and, therefore, the interdependence of factors is not recognised. Actors considering how to improve health look to organisations delivering health care for solutions. Improvement of an individual's health comes through the patronage of medical clinicians.

While the majority of interviewees in all sites directly echoed the systems view of health, many gave reports of colleagues from their own or other organisations who held a more narrow, biomedical perspective. Indeed, differing views of health and partnership appeared to closely parallel the different professional make-up or cultural perspectives of different sectors and organisations. This is explored in the next section.

Differing professional views of health

There were a number of professions that were brought together in HImP and HAZ partnerships. Actors from the health service could represent a number of professional groups (medics, nursing, health visitors, PH and health promotion (HP)) at both management or operational level. Similarly, there were a number of professional groups operating in local government within the different departments such as SS, education, housing and environmental health (EH). Different professional groups held different qualifications and had different career paths and structures which recognised and validated different ways of working. Although professionalism provided specialist knowledge, it also led to people reproducing their own worlds, preventing them from seeing beyond these or relating to work outside their own area of interest or expertise. As a consequence, different professions had different perceptions, values and experiences which shaped their understanding of health and the need for partnership (Hudson 2002).

In statutory organisations, for example, many professionals focused on service-based issues rather than incorporating user/carer perspectives or considering how an issue might relate to the wider determinants of health, prevention or the local community.

“We operate in boxes, and we operate without thinking of the way, of how delivering services affects local communities.” Director, Community Trust

Some professional training, for example, often did not consider how to work in partnership with other agencies.

“[If] you've trained as a housing officer [...] you don't necessarily know how to work in partnership with people from other organisations, and you certainly don't necessarily know how to involve the community in your work.” HP officer, HA

In the health service, the medical profession was widely perceived to be the dominant profession with high status, particularly in Acute Trusts, Mental Health Trusts and PCGs.

“I think the acute service is quite peculiar in a way, because of the dominance of the medical profession in the acute sector. It's even more dominant than elsewhere in the health service.” Director, SS

The medical profession tended to view health within the biomedical framework, and prevention was secondary to their thinking. This perspective also permeated some HA departments.

However, lower status groups working in HAs, such as PH and HP professionals, tended to hold a broader, systems based, ‘social’ model of health in which a population perspective and community involvement were considered important. Most individuals in PH and HP departments considered the partnership approach as central to their work, although some were slow to recognise this.

In LAs, there was a mixture of perspectives on health and partnership which varied between and within departments. The social care profession was dominant, particularly when considering issues relating to health. The social model of health resonated with their professional perspective (non-paternalistic and socially constructed). This group had higher status than other professions such as housing and EH, which also tended towards social models of health, although less than public health professionals (Hudson 2002). There was more of a culture of working with the voluntary sector than health service organisations, which were more closed and less likely to share information. In SS in particular, boundaries to working in partnership with the voluntary sector had started to come down. Education, however, was still resistant to working in partnership.

In the voluntary sector, although no one professional grouping was identifiable, the dominant perspective was a systems view of health and partnership. However, working in partnership was considered more a cultural facet of being generally small organisations with limited resources.

“[W]e've always had to work in partnership otherwise we wouldn't have survived.” Director, VO

Indeed, some in the voluntary sector saw themselves as the embodiment of partnership in that they were often constituted by networks of organisations and worked in a co-operative and consensus-orientated fashion, as did some other small organisations such as CHCs. This contrasted markedly with large statutory organisations which were more hierarchical. However, even in the voluntary sector elements of the narrow biomedical perspective could permeate organisational thinking.

“The medical model of care is [...] a paternalistic model of care i.e. the professional knows best. It's not something that is just part of health service mentality, it can also be part of the voluntary sector.” Director of PCC, Community Trust

These differing perspectives on health and partnership were not static in each sector but changing and evolving, partly in response to the national agenda but also as a result of the educational efforts of HAs in all sites.

How did these different perspectives of health and partnership, propagated by different professional groups, influence the degree of engagement or involvement in partnership? This is considered next.

Professions' views of health, partnership and involvement

Different professional perspectives could lead individuals to categorise the work of health partnership as relevant or not to their work, and therefore influence their willingness to get involved. Thus, involvement appeared weak from departments, organisations or individuals that did not identify with or see the relevance of the health partnership to their work or organisational agenda (i.e. those with a more narrow, biomedical model of health), especially if no additional money was available (as in HImPs).

“[The] initial problem [was] why should we give up our time and resources to help you achieve your objectives. So it was... ‘oh but the health authority should be doing that’, whereas in fact the health authority does very little to promote health and prevent disease.” Manager, HP

In LAs, those individuals or departments who understood the health partnership agenda through a history of working on health or in health and social care partnerships (i.e. joint commissioning or Healthy City partnerships) such as SS and EH could identify with the agenda and were keen to be involved.

However, even in these departments where health was a more recognisable concern, partnership was still a lower priority than for PH or HP departments in the HA. Achieving the government's modernisation agenda was a greater preoccupation, and one for which SS were accountable, unlike the health agenda.

With the exception of PH or HP departments, HAs and Trusts held a narrower view of health and officers were less keen on getting involved. Trusts, for example, did not see their role in the wider systems view of population health and were widely reported to be introverted (focused on accomplishing NHS priorities). Officers struggled to see their contribution to health partnership.

“[W]here you get the wider determinants of what is health, I think [...] the medical clinical staff struggle a little bit on what their role is to that.”
Manager, PCG

Acute Trusts in particular did not consider the HImP or HAZ partnerships as important to their agenda or thought they only had a small role to play. Convincing colleagues of the relevance of the health agenda was considered an important step in improving engagement in partnership.

“[H]earts and minds have still to be won, I think. People don’t see us [in the HImP] as a pivotal part of what we’re trying to do.” Head of Service Planning, Acute Trust

However, for many from this sector, the opportunity costs of participating were considered too high.

“[I]f you come especially from a straight medical background, I think it's really hard especially if it's life and death stuff, to be thinking why the devil am I going to a meeting talking about welfare benefits when this person needs a heart by-pass, this is a waste of my clinical expertise.” Assistant Director of Older People’s Services, HA

Similarly, in LA departments besides SS (such as housing and education) many officers and members saw health as a health service issue. Although this attitude was less prevalent among senior managers, there were still many members who could not see the need. Lack of appreciation of their contribution to the health agenda due to a narrow perspective left some actors confused as to why they had been invited to attend HImP partnership meetings.

“[O]ne representative from housing couldn't work out why he was there at all, I had to spell that out but I still don't think he quite understands.”
Director of Strategy and Performance Management, HA

Even where there was an initial willingness to be involved in partnership, nagging doubts about the benefits would emerge, particularly when much of the agenda was perceived to be of little relevance. This was contrasted with the resources (time) invested.

“Colleagues sometimes from housing and education have found it difficult to sit through whole meetings when they can only perceive perhaps 2% of it that they're involved in.” Assistant DPH

Even in LA departments with a history of working on health or partnership (i.e. EH) there were still mixed attitudes, with many officers seeing health only in terms of enforcement, hygiene and environmental standards. Issues beyond this were a matter for the health service or SS.

Education departments were particularly reluctant to get involved, considering health as SS's territory. Although education professionals were not schooled in a particular perspective on health, historically, education policy was reported to be more interested in educational standards than inequalities in educational achievement. Many officers therefore could not see how the health and inequalities agenda was relevant to them.

In the voluntary sector too, there was some lack of understanding about their role in improving health, even if many voluntary organisations were familiar with the agenda, and the need to work in partnership. However, as we shall see later, this did not stop them from trying to engage. A summary of the different health and partnership perspectives/attitudes generally held by organisations/sectors is presented in Appendix M on page 402.

Professional concerns for delivery or action

Understanding the agenda and recognising its relevance to organisational interests was an important factor in ensuring involvement. However, even if respondents had a systems view of health partnership, many were still concerned about the practical outcomes of partnership as well as the costs of participating.

Involvement in partnership could also be undermined by individual scepticism about whether a partnership could deliver a joint agenda, or its perceived lack of action or influence over partner organisations. If a partnership was perceived as a ‘talking shop’ not delivering action, then the cost of engaging in partnership might be thought to outweigh the benefits.

Having to work in strategic health partnership was a ‘culture shock’ for many individuals in the statutory sector i.e. GPs and LA departments other than SS. Some service managers saw the portfolio approach to tackling service issues in partnership as an attack on their profession.

“[It] causes some people great problems because some people see this as killing off their professionalism.” Director, LA

Even when there was verbal agreement over an issue, achieving change to service provision was difficult. A fixed mindset, cautiousness about changing work boundaries, fear of losing control or lack of clarity over future roles were reasons cited.

Indeed, taking a broader health perspective could actually threaten a professional’s resource base, particularly for those in the health service.

“If we’re going to invest in health, you know, in group [population] health, we don’t invest in the health service.” Manager, PCG

On the other hand, there was an acknowledgement that the engagement of professionals in partnership was a resource in itself, bringing access to different information and expertise. This could be used to improve services or identify areas of duplication.

“[We] all pulled people together from the NHS, then social services and housing, and said, how do you view people in other organisations in care of the elderly [...] and we found through doing that, that there's a great deal of similar core work [...], and we're now looking at can we develop core competencies for support workers, can we look at common areas of training for NVQs.” Assistant DPH

Partnership could also provide a forum to challenge professional assumptions. Exploring differences could provide a creative force in tackling difficult issues in ways that might not have been envisaged before. Indeed, in Collaboration Theory, such innovation usually forms part of the rationale used to justify the partnership approach (see Chapter 6 for a more detailed discussion of this ideal).

“[W]hat the HImP does is make us think about other, slightly less obvious things that we might not have, you know, been quite so worried about, if it hadn't been drawn to our attention.” Head of Service Planning, Acute Trust

In sum, professional perspectives were a significant factor shaping perceptions of the value of partnership.

4.3.3 Key individuals or actors

This section examines briefly the role of key individuals in partnership. Although key individuals did not appear to influence directly other actors' perceptions of health and partnership, it is through individuals that the balance of the costs and benefits are made, and consequently, on which their resultant behaviour is based. Individuals who are charismatic or in a position of authority could, therefore, exert an influence which shaped the degree of involvement of their organisations in partnership or how the partnership itself might develop. Indeed, the role of key individuals in partnership was recognised by nearly two-thirds of (39/60) coded interviewees. One key individual may

have an undue influence on involvement in partnership. This could be either positive or negative and could affect the structure, process and outcomes of partnership.

The attributes of key individuals

There were a number of factors that made individuals key: an individual's ability to effect change either due to an inherent or learned skill, their position/power within a partnership or organisation, or their personality.

Key individuals were therefore either *tacticians* (Challis, Fuller et al. 1988), 'wheeler dealers' or 'fixers' who knew how to 'get things done', and had the inter-personal skills to pull it off. In this way, they were able to push or keep the partnership agenda afloat in their own organisations. Alternatively, key individuals were senior figures, such as directors or CEOs. Seniority, although 'symbolically' important as a sign of organisational commitment to partnership, was not sufficient on its own. Individuals had to have credibility with other partners if they were to carry influence or 'clout' and be capable of effecting change to their own organisations. Finally, individuals with strong or forceful personalities or with charisma could, for example, either drive change through imposition of their views or enthuse or inspire others to work in partnership, by providing drive, vision and leadership.

The impact of key individuals with one or more of these attributes on organisational involvement in partnership or on the development of partnership would depend, in part, on the individual's attitudes towards health and partnership.

Thus, key individuals who had a broad perspective on health understood the agenda and could recognise the potential benefits it could bring. Such individuals were described as forward thinking and flexible, 'passionate' or 'enthusiastic' and appreciative of the need for voluntary sector involvement. As such, they were willing to commit time and energy to the partnership process, even champion the cause to others.

“Injury I suppose is quite well embedded in the HAZ and in the HImP programme, and that is partly to do with charismatic personalities. There is a chap at the institute [...] when [he] comes along he talks in quite a charismatic way, he makes what he is talking about quite interesting, and so people remember what he is saying. Unfortunately there aren’t very many people like that around.” Non-Executive Director, HA

The activity and behaviours of these key individuals showed elements of collaborative leadership and social entrepreneurship (De Leeuw 1999; Huxham and Vangen 2000b).

On the other hand, key individuals with their own agenda, who were not prepared to compromise or able to shift their perspective, or were of ‘fixed mind’, could be disruptive, even detrimental to partnership. This was especially the case when the key individual had a strong, forceful personality. This could lead to a personality clash, disagreement and confrontation more based on character than substance.

If key senior officers were advocates of partnership, this could provide a powerful combination of political and organisational resources to influence their and other organisations’ involvement in partnership, especially if the individual had a pivotal role in the partnership.

“[H]aving [the Assistant CEO] as chair has made an enormous difference. And it’s both his position and him as a person. But he will go to the point at which he’s responsible for his authority.” HC Co-ordinator

The role of key individuals appeared particularly influential in two study sites. In Greenshire, the CEO of the HA was a strong advocate of partnership and was the only CEO in the study sites to actively chair the HImP partnership. As a former employee of SS she understood the agenda and had cultivated good relations with local government officers, particularly SS but also education. This had led to the establishment of a joint commissioning unit within the HA, ‘perhaps the first in England’ headed up by the Assistant Director of SS who was jointly employed by the HA and LA.

By contrast, in Dalesville the HA CEO was the chair of the HAZ. While she recognised the value of the health partnership, she still saw control of the HAZ as very much the domain of the health service. Her strong personality imposed itself on the HAZ, HImP and other local health partnerships, influencing the structural arrangements and the nature of relations between partners.

Her transparency and motives were questioned and she operated in an inconsistent manner. This made it very difficult for other partners to work with her, resulting in tension with key senior officers in the LA (and the HA).

“[T]here’s a track record of bad feeling, it’s personal but between [the CEO] and most of the other partners, she’s managed to piss most of them off at some point.” HAZ co-ordinator

She strongly influenced the structure and membership of HAZ and HImP partnerships as well as HAZ priorities, forcing it to take a project rather than a strategic approach.

“We would have preferred to have gone with a HAZ bid that was not tied down to too many projects, far less projects than we actually had with more monies against broad headings that you can then take a more kind of commissioning approach to, to try and generate new sorts of ways of doing things. But we were forced really by [the CEO] saying no I want projects.”
Director, VS

In summary, the perceptions of the relative benefits and drawbacks of engaging in partnership appeared to influence actors’ decisions about their degree of active involvement (Lasker, Weiss et al. 2001). Perceptions appeared to be influenced by attitudes to health and partnership which, in turn, were largely shaped by professional perspectives. The orientation of that perspective could shape how organisations or individuals viewed partnership. In particular, whether they saw participation as beneficial to their work, bringing access to financial or informational resources, generating new ways to tackle different problems, reducing waste through identifying duplication of activities, or, as an irrelevance to their agenda, an activity which they had little to contribute to or gain from and which could threaten to undermine their

professional interests. These attitudes varied by profession and position across and within organisations, and, therefore, the propensity to engage in partnership varied as the perception of costs and benefits of participating in partnership varied. Across case study sites, similar patterns of involvement appeared to emerge with respect to perspectives on health partnership. Professional perspectives also shaped the perceptions of resource costs and benefits of involvement in partnership, with reference to the national policy agenda and reform and local structure, and organisational boundaries. How these combined or were enacted determined the degree of engagement in partnership.

This was in part dependent on key individuals – actors able to influence others because of a combination of their tactical skills, personality or formal authority. Key individuals could push the degree of organisational involvement in partnership according to their views and perspectives on it and the perceived costs and benefits of doing so. The impact of individuals could have a dramatically different impact on levels of involvement. However, actors’ judgements about degree of involvement in partnership also appeared to be influenced by the size of the resource base of an organisation as well as its resource dependencies with partner organisations. These are considered next.

4.3.4 Resource base and resource dependencies

Size of resource base and nature of local resource dependencies are the final factors outlined in Figure 4.1 that appeared to be very influential on how actors assessed the costs and benefits of partnership, and, to some degree, how actors behaved in partnership. Both these factors help determine the nature of relations, and whether they are symmetric or asymmetric. In Resource Dependency Theory, the symmetry of relations is hypothesised as not only important in determining behaviour and involvement in partnership (Challis, Fuller et al. 1988) but also the degree of influence or power one party has over another. This section describes how the size of an organisation’s resource base appeared to influence actors’ assessment of the resource costs and benefits of involvement in partnership. It then goes on to describe the general nature of resource dependencies in HImP and HAZ partnership. However, it does not

consider the dynamics of resource dependencies. This is left to Chapter 5 where it is shown how the factors in Figure 4.1 combined to give a general pattern of involvement in partnership, whilst explaining particular behaviour in each study site.

Size of resource base

The size of resource base appeared to be influential on an organisation's involvement in partnership, particularly in HImP partnerships where there were less additional resources available to partners. Local organisations could be considered as falling into two categories – large and small resource base.

Those organisations with a large resource base were mainly statutory organisations. These included HAs, LAs and NHS Trusts (as well as the Police and Fire Service). Typically, these employed several hundred staff and had budgets of several hundred million pounds. However, not all statutory agencies had such large resource bases. PCGs, CHCs, Probation, RECs had relatively small resource bases as did non-statutory organisations (i.e. voluntary sector organisations). Staffing for these organisations was in the order of tens. (The private sector was not involved in local health partnerships and its resource base is not considered.) Table 4.3 crudely locates participating organisations into these two categories based on human and financial resources. The figures are approximate, as exact figures varied within and between organisations, sectors and sites.

The size of resource base appeared to be influential on the assessment of organisational costs of involvement. The relative cost implications of involvement in partnership per person for organisations with a large resource base was less than those with a small resource base. In large statutory organisations, staff time and administration and support costs could be subsumed with relative ease.

The relative costs to organisations with a smaller resource base such as PCGs, CHC and

Table 4.3. Size of resource base typical of organisations in health partnerships

Organisational sector	Human resource (Staff numbers)	Approx. budget size (£million)
Large resource base		
HA – Overall ¹	260	£217 – Middleton £328 – Dalesville £349 – Metrocity £426 – Greenshire (baseline)
LA – Overall	16,000 (eg. Middleton)	£342 – smallest study site (Middleton) £755 – Unitary £782 – County & districts (Greenshire)
LA – SS ²	1,400 ⁵	£118 ⁵
LA – Education ²	1,300 ⁵ (excl 3,500 school staff)	£295 ^{2,6}
LA – Housing ²	830 ⁵	£145
LA – EH ²	300 ⁵	£8
LA – Leisure ²	300 ⁵	£31
Trusts (acute)	1500-7000	£27 ⁷ -£120 ⁷
Trust (community)	400	£91 ⁷
Trust (MH)	400	£21 ⁶
Small resource base		
PCGs	4-10	£3-£20 ⁷
CHC	18-24 ³	
Voluntary sector ⁴	10	£0.04 ⁷

¹Figures for 2000/01 (DoH 1999e)

²Figure for a typical UC 2000-01(Leach and Percy-Smith 2001b, p137)

³Figure for a typical CHC (European Observatory on Health Care Systems 1999)

⁴Many voluntary organisations worked on health issues or some related issue (i.e. in Greenshire this was estimated as 70 out of 80 local organisations and in Middleton it was approximately 70 out of 220) although many were not involved directly in health partnership.

⁵Figures taken from an average-sized metropolitan authority with a population of approximately 220,000. EH and Leisure have a combined staff of 600.

⁶Greenshire Health Authority (1999)

⁷Dalesville Health Authority (1999)

the voluntary sector groups was larger and these organisations struggled to provide the organisational resources for partnership.

“We got no slack whereas a lot of the other chairs are chief execs of sort of huge organisations and they can swallow up their secretarial time and everything else.” Director, VO

This was, of course, ultimately dependent on how many members of staff organisations fielded in partnerships (and this proportion in relation to the total number of staff).

But while administrative and computer resources were considered helpful in supporting voluntary sector staff to sit on partnership groups, they were considered less helpful in developing organisational links with a wider constituency. Some smaller organisations with an area-wide brief found it particularly difficult to attend all the relevant partnership meetings in each locality, either for financial reasons or lack of organisational capacity.

Indeed, those in the voluntary sector perceived HAs and LAs as more willing to supply human or IT resources than financial support, but it was the latter the voluntary sector required. As one middle manager noted:

“People seem to find it easier to give of their human resource time or their IT time or their admin time than actually physical money.” Manager, HA

Committing monetary resources to health partnership, whether to support the process of partnership or the programme of work, presented difficulties for all organisations, even for large statutory organisations (preferring to use JF rather than mainstream funds).

As it will be shown in Chapter 5, this was partly related to the resource scarce environment in which many organisations found themselves – a condition imposed on statutory organisations by central government.

Nevertheless, while a small resource base posed a significant barrier to engagement in partnership, it did not prevent small organisations getting involved in partnership. Rather, it just limited the extent of their involvement. Indeed, many small organisations appeared overly willing to bear these costs, as will be shown in Chapter 5. The nature of

their resource dependency relations (with the HA, for example) appeared to be an influential factor in this decision.

4.3.5 Resource dependency

The nature of resource dependency relations between organisations appeared to be an important factor in determining the nature and level of engagement in partnership. In all sites, there was a complex array of horizontal and vertical resource dependencies amongst statutory and non-statutory agencies in health partnerships. The single most important resource for all public authorities and the voluntary sector is money (Leach and Percy-Smith 2001b). Most statutory agencies are vertically dependent on central government for financial resources, either directly or indirectly. However, as resource dependency theorists point out, dependencies are not just about obtaining finance but about providing services and information etc in exchange, thereby creating reciprocal relationships or interdependencies. This section describes the nature of resource dependencies in greater detail.

Vertical dependencies

Although central government was dependent on statutory agencies to enact its policy agenda and preferences, local statutory agencies were by-and-large dependent on the centre for resources. Thus, there was a strong resource (inter)dependency relationship between statutory agencies and central government. HAs in particular had strong vertical dependencies for financial resources. LAs were slightly less dependent on the centre with just under half (48%) their revenue from government grants, the rest coming horizontally from local taxation (council tax (25%) and business rates (25%)) (Leach and Percy-Smith 2001b, pp.139; DoH 2002b). Other small statutory agencies such as CHCs are very dependent on central government for funding. CHCs for example, were funded from a national budget held by the NHS Executive but were independent of the NHS management structure (European Observatory on Health Care Systems 1999). NHS Trusts and PCGs, on the other hand, had indirect vertical dependencies, their resourcing being negotiated and managed horizontally by HAs. The strong vertical dependency of HAs and LAs on the centre for resources was demonstrated in Chapter 3.

In the health service, in particular, there was strong compliance with the centre's wishes, facilitated by linking additional funding (such as Modernisation Funds, HAZ etc) to its policies and priorities, supplemented with specific conditions and close monitoring of performance. This created strong vertical dependencies.

Horizontal dependencies

There were horizontal dependencies between HA and SS, particularly in services where there was joint health and social care provision – the care of older people, or people with mental health problems, learning or physical disabilities. This interdependency has been growing since the 1970s, when many individuals in long-stay hospitals were moved out into the community, in response to a succession of government policies emphasising independent living and supported, community care (DoH 2001f). Other government policies have resulted in the length of stay and number of acute beds falling (DoH 1987-2001). As a result there was growth in community based services, coupled with a relative increase in SS spending on social care when compared to HAs and Trusts (DoH 2001f). The management of this transition reinforced the interdependence of HAs, Trusts and SS through the negotiation of associated resource transfers to assist with the cost of community care. Furthermore, there were a number of different funding streams and sources, such as Section 28A payments and JF, with different purposes and requirements⁶. In response, many HAs and SS negotiated local arrangements (Forsyth and Winterbottom 2002). However, what constituted social care (as opposed to health care) was not clearly defined and the level of payments flow between agencies was often disputed (Nocon 1994). The result was a complex arrangement of care provision and, therefore, resource dependencies between HAs and SS.

In Dalesville, this dependency relationship became particularly important when the HA tried to change the resource flow in an existing exchange relationship. This came about

⁶Section 28A funding is a dowry given to HAs for those people living in old long-stay hospitals and includes an element for social care. The 1992 guidance (HSG(2)43) on HA payments states that 'if local authorities assume prime responsibility for arranging care for particular groups any transfer of responsibility should be reflected in a transfer of funds.' However, as government officials recognise, the social care element is only to assist in the cost of community care and may not be sufficient to meet the full cost (Ellis 2000). In many areas, this has placed an increased financial burden on LAs, as noted in Chapter 1.

when the HA proposed to reduce its large supply of long-stay care beds in community hospitals in order to re-locate patients in the community, with potentially large resource implications for SS. Table 4.4 shows the size of old long-stay specific adjustments to HA resource allocation by the DoH for 1999/00 – the sum of money that is used to support individuals being cared for in old long-stay beds. For an HA of similar budgetary size to Dalesville (Metrocity) but with no long-stay beds, the difference in resource allocation was approx. £5 million. This included an element for social care. Although only a proportion of this would be transferred to SS, there was likely to be knock-on costs for SS as funding from the DoH did not cover the full cost of care in the community⁶. Such a move, therefore, was likely to increase the financial burden on an already cash-strapped SS. This threatened change to the resource dependency had a profound impact on the development of the HImP and other health partnership arrangements in this site. This is discussed in detail in Chapter 5. However, this was less important in other sites where the number of long-stay beds had been significantly reduced during the 1990s (see Table 4.4).

Table 4.4. Specific adjustments for old long-stay patients moved into care into the community for 1999/2000, by case study site (£ million)

	Dalesville	Greenshire	Metrocity	Middleton
Specific adjustments – old long-stay (£million) ¹	0.9 ²	-4.4	-4.1	-2.1
Average number of adults with learning disabilities in long-stay occupied beds ³	27	0	0	0

¹Figures as of 11/1998 (DoH 1998i). The HImP shows Section 28a payments as £4,248,000 (Dalesville Health Authority 1999)

²The approx difference for a similar budgetary-sized HA such as Metrocity is ~ £5 million (£0.9 minus -£4.1).

³Data from Forsyth (2002). This does not include mental health beds or people in hospital or prison. KH03 data from the DoH (1999-02) shows no residential beds for MH patients in Dalesville (DoH 1987-2001)

NHS Trusts were indirectly dependent on the centre for resources, which it received via the HA. However, exact allocations were negotiated bi-laterally with HAs outside or on the margins of the HImP in the SaFF. Trusts were therefore horizontally dependent on

HAs for their funding while Trusts provided a specified level and quality of services in return for financial resources. However, some Trusts had a lower dependency on HA funding, especially in more urban areas where teaching hospitals received perhaps as 'little as 15% of their funding' from this source, the rest coming from alternative sources such as neighbouring HAs, research grants and private income. Thus, for some Trusts HAs' resources were less important, with a degree of substitutability. This was the case in at least one of my case study sites. Acute Trusts also had organisational dependencies on SS, particular in the area of intermediate care and hospital discharge. Patients could become 'bed blockers' if the Trust was unable to move them into accommodation funded by SS, undermining a Trust's performance in achieving government targets. Thus, rates of discharge had potential financial consequences for Trusts (and SS) and, therefore, both vertical and horizontal dependencies.

Community Trusts were also heavily horizontally dependent on HAs for resources (although indirectly to DoH). The level and type of service provided by Community Trusts were negotiated bilaterally with HAs, outside or on the margins of the HImP. Areas of joint service provision with SS (and the voluntary sector) were also decided outside the HImP in the JIP. An additional source of funding available to Community Trusts was JF money (renamed Innovation Funds), created specifically to encourage inter-agency working. Although the level of joint finance was set by central government (DoH), allocation of funds was decided locally by the JCC.

Similarly, PCGs had a heavy horizontal dependency on HAs for their funds. Most PCGs in the study sites were Level 2 and did not have direct control over budgets to commission services. Spending plans were agreed bi-laterally with the HA in the PCIP. Thus, PCGs were dependent on HAs for human and administrative resources rather than funds for purchasing services. In the first year of HImPs, PCGs were being set up and established, effectively operating as 'shadow organisations'. Existing health partnerships (such as HC/HFA) also had heavy horizontal dependency relations, primarily being funded by both HAs and SS.

The voluntary sector was also fairly heavily dependent on both HAs and LAs for funding, either through JF or grants allocated to SS or other LA departments by central government. These funds were mainly to support the delivery of services but some went towards organisations' work as advocates. A report commissioned by the HA in Middleton, for example, identified the resources of the voluntary sector as at least £10 million, 60% of which was provided by statutory agencies. However, this dependency relationship was often based on short-term grants (i.e. specific grants and JF monies), usually up to three years. Indeed, the arrangements by which the voluntary sector could access these funds appeared to be very influential on their involvement in health partnerships. The literature on inter-organisational relations recognises stability as a predictor of partnership formation, reducing environmental uncertainty such as resource scarcity, availability of exchange partners etc (Oliver 1990). Two issues in particular, which relate to the sector's resource dependency relationship, were highlighted by interviewees (independent of site and sector): the level of funding and the funding arrangements (continuity and structure).

Level of funding

The level of funding was often influenced by the level of external monies available to the statutory sector and therefore in the main relatively small. These resources went to support voluntary sector networks or partnerships, or health workers, usually based in umbrella organisations such as VSCs as well as a number of community development workers and community forums and panels. The result was that the voluntary sector's resource base or infrastructure was mixed within sites and between sites, and in general, small. Funds were considered insufficient to actively participate in partnership and fulfil a representative role. Lack of support was also taken as a sign by the voluntary sector that its involvement was 'not a high priority' for the statutory sector or that the statutory sector fundamentally misunderstood what was required to involve it in partnership.

“[W]illingness is couched in a lack of real understanding of what it means, what has to be delivered by the agencies, to actually take the black communities on board, and their needs. And you know, the notion that one worker can do that, just obviously, I think, highlights that, that is a very limited understanding of the complex nature of involving communities, and

accessing their views, and getting them involved in partnerships.” Officer,
REC

Funding arrangements

The lack of continuity of funding by the HA or LA could also disrupt the voluntary sector’s involvement in health partnership. This was in part a direct consequence of the nature of voluntary sector funding which was contractually based rather than core funded. This created a bureaucratic and uncertain process whereby funds often stopped after three years, whether the funded project was considered effective or not. A break in funding could result in good projects falling ‘flat’ or unnecessary loss of staff together with the skills and knowledge they had acquired.

Finally, the structure of funding arrangements for the voluntary sector could also create barriers to the voluntary sector working in partnership with itself. Bidding processes, for example, could be divisive as organisations were forced to compete for resources. This process could consume significant resources without any guarantee of financial return. Furthermore, the new organisational structures fragmented funding, particularly in rural areas, resulting in the voluntary sector submitting multiple bids, one for each locality. This duplication resulted in higher transaction costs and greater uncertainty.

The most notable exception to this was in Greenshire where one voluntary organisation, after 10 years of fruitful interaction with the HA and SS, had negotiated a Compact. This helped stabilise dependency relations by formally setting out funding arrangements and commitments and processes for their change. As will be shown in Chapter 5, the size of resource base and stability around funding appeared to influence the behaviour of organisations.

However, voluntary groups had access to other sources of funding beyond the statutory sector, such as external grants (i.e. NOF), public donations and membership fees. A summary of horizontal and vertical financial resource dependencies is given in Table 4.5.

Thus, study sites had an array of vertical and horizontal resource dependency relationships in place before and after HImP and HAZ partnerships were established. The behaviour of organisations appeared to be strongly influenced by the degree of horizontal resource dependency, particularly when coupled with resource base. The cost-benefit calculations of organisations with high horizontal (or in some cases vertical) dependencies but a weak resource base appeared to be markedly different to organisations with either a strong resource base or weak horizontal dependencies. However, the other factors set out in Figure 4.1 also interplayed with actors' assessments of involvement in HImPs or HAZs, combining in each site to explain general patterns of involvement whilst still allowing for local discrepancies. For this reason, the engagement and behaviour of HAs, LAs and Trusts in health partnership is considered separately to organisations with a small resource base in the next chapter.

Table 4.5. Summary of local resource dependency relations by organisation/department across study sites.

Organisations	Horizontal dependencies	Vertical dependencies
HA	SS	DoH
LA – SS	HA, Local taxation	DoH, DETR, EU
LA – EH	Local taxation	DETR
LA – Leisure	Local taxation	DETR
LA – Education	Local taxation	DfEE
LA – Housing	Local taxation	DETR
Police, Fire, Probation ¹	LA	Home Office
Trusts	HAs, PCGs, other (research funds)	DoH (indirect), capital (PFI)
PCGs	HA	–
CHC	HA	DoH
Other statutory organisations (i.e. REC)	LA	CRE/Home Office
VS	HA, LA, other (NOF)	Specific grants (indirect)

¹Fire and Probation are now under the Office of the Deputy Prime Minister (ODPM)

4.4 Conclusion

This chapter has explored the influences shaping horizontal relations between individuals and organisations in case study sites. It used Resource Dependency Theory

as a framework to explain the degree of involvement and the nature of engagement between individuals, organisations and different sectors.

Part I of the chapter showed that actors were acutely aware of the resource implications of partnership, either positively or negatively. Establishing, maintaining and developing partnership was identified as consuming human, administrative and financial resources by almost all interviewees, from all sites and sectors and recognised as immediate and ongoing. Benefits could be concrete where additional funds were available, or less tangible where they related to improved inter-organisational relationships, awareness, perspective and potential outcomes. Not all actors recognised these. However, there was widespread recognition that the benefits of partnership would take time to realise and was contingent on resource investment, which was particularly heavy during the start up phase. Part II showed that actors were making cost-benefit calculations and that these were influenced by the availability of resources and the perceived impact of partnership on an organisation's or individual's interests. Respondents from all sites and sectors identified a number of different issues that shaped and influenced the perceived costs and benefits; national policy, structure and boundary changes; local structures, organisational boundaries and local politics; and organisational culture & professional training.

The relative weight of these factors in their cost-benefit calculation appeared to be dependent on each actor's own perceptions about the relevance of the health partnership agenda to them, influenced to a large degree by their professional background. Calculations were also very sensitive to the resource environment of respective organisations which, in general, was resource-scarce. These factors were bipolar and summative in that they could have a positive or negative influence on actors' perceptions of the costs and benefits. A schematic representation of how an actor's perception of these factors contribute to the assessment of costs and benefits was presented in Figure 4.1. The role of key individuals was also considered briefly, as it is through actors that these calculations are made and on which their resultant behaviour is drawn.

The results of this chapter appear to support some of the basic assumptions behind RDT, namely that actors assess the resource costs and benefits of inter-organisational interaction, whether financial, political or informational. The national and local context shaped the assessment of these resources. However, self-interested motivation appears to be tempered by perspectives on health and partnership, in that those with a broader perspective were more tolerant of the costs and more optimistic about the benefits of partnership. In its extreme, this might be interpreted as altruism. However, while this chapter shows how actors make an assessment of the costs and benefits of partnership, it does not relate this to the degree of involvement in partnership. The driving force behind Resource Dependency Theory is not only the opportunity to seek needed resources, but also the symmetry of resource dependency relations and the availability of alternative resources. How these factors interact dynamically to explain different patterns of organisational involvement across and within study sites is considered in the next chapter.

Chapter 5 – Dynamics of horizontal relations - a resource dependency perspective

5.1 Introduction

This chapter explores the nature of horizontal relations between organisations in health partnership in greater depth. It uses Resource Dependency Theory (RDT) as a model to help explain the level of engagement of different organisations in health partnership. It builds on the previous chapter in which it was shown how individuals and actors make an assessment of the costs and benefits of being involved in partnership. It shows how the differing patterns of organisational involvement in health partnership across sites and within sites can be explained by the dynamic interaction of the factors identified in Figure 4.1 in the previous chapter. The behaviour of actors and the nature of relations within partnership is also examined using RDT as a framework. Consideration of the symmetry of resource dependencies between organisations allows an exploration of power relations in partnership. The chapter, therefore, contributes to my second research question: what was the nature of local horizontal relations and what factors were perceived to be influential in driving and shaping local health partnership? In so doing, it seeks to address whether this health partnership could be considered partnership as *participation*, as conceptualised in Chapter 1.

As noted in Chapter 4, RDT assumes that voluntary interaction and resource exchange between organisations is driven by self-interest, with actors making calculative assessments of inter-organisational relationships in order to enhance their access to resources without compromising their interests or autonomy. Analysis of interviews identified a number of factors that appeared to influence actors' assessment or perception of interests, and a schematic representation of how these combine and interact was presented in Figure 4.1. However, interaction within an RDT framework is not as straightforward as the diagram might suggest. Two factors in particular appeared to strongly influence the behaviour of actors and the nature of relations in partnerships

in all study sites – the size of resource base and the symmetry of resource dependency relations.

RDT argues that inter-organisational dynamics are not just dependent on actors' calculative assessment of the need for resources but also on the *substitutability* of resources; whether alternative sources are available. Access to alternative resources creates different levels of dependency between organisations. It is the nature of this dependency – whether it is balanced (symmetrical) or skewed (asymmetrical) – that has significant implications for the behaviour and the nature of relations between organisations, as noted in Chapter 1.

Organisations with a high, symmetrical need for each other's resources (*mutual dependence*), in part due to the lack of alternative sources, have a high interest in maintaining exchange relationships (Scharpf 1978). However, this situation can also generate mutual vulnerability where each party is concerned not to disrupt the balance. This may constrain the work of partnership as each party sticks to legitimate zones of work so as not to upset the other partner (Scharpf 1978).

In intra-organisational relationships with a high, asymmetrical need for resources (*unilateral dependence*), on the other hand, resource exchange may occur on the terms dictated by the organisation which controls the critical resources. As lack of compliance with these terms risks jeopardising access to resources, power and influence are unequal. Consequently, less powerful organisations may try to change the underlying nature of the dependency relationship and seek greater influence over resource exchange.

The nature of dependency relations is linked to the size of an organisation's resource base, as larger organisations, for example, will tend to have relatively less need for a resource than smaller organisations, as noted in Chapter 4. A resource-scarce

environment may also impact on dependency relations, by limiting access to needed resources.

This chapter is structured around the size of resource base and the symmetry of resource dependency relations, as these two factors appeared to carry significant influence in relation to the behaviour and influence of actors in health partnerships. As organisations in all sites reported resource-scarce environments, this factor could not be considered as a separate variable.

The chapter is structured in two parts. Part I considers the degree of involvement in, and nature of relations between organisations in health partnership with a large, fairly symmetrical resource base, such as HAs, LA departments and some NHS organisations (Trusts). Part II focuses on the behaviour and nature of relations of organisations in health partnership with small, asymmetrical resource-bases, namely the voluntary sector and PCGs but also other small statutory organisations (i.e. CHCs). Since influence over decision-making and resource exchange in asymmetrical dependencies is more likely to be the product of power relations, this part addresses whether the partnership as *participation* was evident. Finally, a summary of both parts is presented and interpreted in terms of RDT.

Part 1

Involvement of large, symmetrical resource-based organisations (HAs, LAs and Trusts)

This part focuses on large statutory agencies such HAs, LAs and Trusts in health partnership, in particular the degree of involvement in health partnerships and the nature of relations between these organisations. All had large resource bases and varying degrees of horizontal dependency between themselves and vertical dependency on central government. However, horizontal dependencies between organisations were fairly symmetrical – there was *mutual dependence*, while vertical dependencies with government tended to be more asymmetrical; local organisations were dependent on the resources of large government institutions (and the centrally imposed rules attached to funds), but these institutions were also dependent on local organisations to deliver.

In a resource-scarce environment, RDT would predict that these organisations would seek to develop horizontal relations to increase access to resources as long as interests were not threatened. Indeed, Chapter 4 indicated that some organisations were motivated by access to resources, albeit vertical ones (i.e. HAZ funds). How did these organisations respond? Was there interest in developing exchange relations or did mutual vulnerability result in organisations identifying legitimate areas of work which did not threaten existing dependency relationships? In this part it will be argued that large resource-based organisations did not want to fundamentally change resource exchange relationships through health partnerships. Indeed, health partnerships (HImPs and HAZs) appeared to have little influence over mainstream resources, with allocations occurring outside the structure. However, statutory organisations had an obligation to participate regardless of the development of exchange relations. Thus, organisations remained sensitive to the resource and autonomy implications of partnership, especially in a resource-scarce atmosphere.

Part 1 begins by examining how actors in different large resource-based organisations and their departments perceived the resource implications of involvement in partnership

for each of the factors identified in Figure 4.1 in Chapter 4. It shows how these factors combined dynamically to explain the differing patterns of involvement in health partnership across and within sites. It then moves to focus on the nature of relations between these organisations in health partnerships and the extent to which resource exchange resulted in changes in policy or resource allocations or interaction was confined to small areas of work which did not upset the existing symmetrical dependency relationship.

5.2 Health partnership as an opportunity to access or exchange resources?

5.2.1 *Health Authorities (HAs)*

HAs in all sites were actively engaged in health partnership but to varying degrees and in different ways. The health partnership agenda was widely welcomed by all. HA staff interviewees – both junior and senior – saw it as an opportunity to improve health and reduce inequalities. Indeed, in all sites, HAs were already involved in health partnerships and had already committed human and financial resources (mainly JF monies) to them prior to the New Labour administration. Two sites, Metrocity and Dalesville, had achieved HC status from WHO with some of their partners which involved joint funding of co-ordinators. However, only in one site, Middleton, was there a more strategic partnership, the others mainly involving less senior or junior officers and centred around projects.

Nevertheless, HAs' involvement was strongly influenced by the national agenda as evidenced in Chapter 3, not least because the policy agenda and supporting legislation placed a duty of partnership to oversee the development of HImPs. Involvement was therefore expected by the centre. However, the degree of engagement in partnership was less easy for the centre to determine. The lack of additional resources to support HImPs from the centre did not provide a financial incentive to engage. This contrasted with the availability of HAZ funds, which did appear to be an incentive to form voluntary partnerships in the two case study sites that qualified. On the other hand, the national

agenda helped legitimise actors in HAs who believed in a broad systems perspective on health, moving health partnership out of public health departments and into the mainstream. On the other hand, as noted in Chapter 3, the national agenda also undermined HAs' efforts to support the development of partnership: the resource-scarce environment, lack of additional resources to support partnership, the large change agenda (policy and organisational), tight deadlines imposed by the centre, pressure to achieve financial balance, squeezing organisational resources (human, financial). HAs were committed to engaging in partnership but central pressure to deliver the health service agenda, linked with resource and autonomy sanctions, left organisations considering the opportunity cost of involvement. This cost was exacerbated by the fact that all sites had maintained their joint commissioning structure with a view to dismantling them when the new partnership arrangements had developed. In rural HA districts where there were more organisational boundaries, the costs of involvement were slightly higher as there were more administrative costs associated with a large number of members.

Thus, the resource cost of engaging in partnership was balanced against the potential costs of not achieving the national priorities. Given that the benefits of the HImP were not immediate or financial in nature, the balance swung more in favour of dedicating resources to achieving the national agenda, with the HImP partnership coming second.

“[T]he health authority sees as its primary purpose, as balancing the books, and only after that is it interested in improving health.” DPH

Nevertheless, HAs did commit resources to health partnership. This was mainly human and administrative resources, costs that were easier to bear for an organisation with a large resource base.

“[W]e've put dedicated resource into the HImP process [...] I don't know how much, might be £50,000 which is not a small amount of money for a health authority doing all the sort of management cost coshes that they are under.” DPH

Human resources included actively involving senior as well as junior staff, such as the Director of Public Health, Health Planning or Commissioning, even the HA CEO (in Greenshire HImP and Dalesville HAZ), and funding or providing a HImP lead. Senior officer involvement also increased in HC and HFA partnerships as HAs sought to develop them into strategic partnerships (Dalesville and Metrocity). Their funding was maintained in all but one site (Greenshire) where it was reallocated to support the HImP. The extra workload of partnership was on top of staff's regular job.

Former JF monies (and HAZ funds) were also used to support the development of health partnership in sites, going towards employing a co-ordinator, a number of development days and educational seminars, and providing limited financial support to the voluntary sector (secretarial/financial) and also development funds. The allocation of core HA funds to support the process of partnership was not evident in any sites. Resources came from a re-organisation of existing additional funds (i.e. JF) and by increasing staff workload.

The resources committed to partnership could be considered relatively small compared to the size of the HA's overall budget and staff base. However, some senior officers did not consider it small, given the financial pressures to reduce management costs and redirect every 'spare penny' towards PCGs. On the other hand, some HA respondents with a broader view felt that the resources available were insufficient to meet the proactive vision and not enough had been invested in its development to reap the benefits.

5.2.2 Local Authorities (LAs)

LAs were the second most involved organisations in health partnerships across all sites, both in HImP and HAZ partnerships. However, the degree of involvement of different LA departments showed a common pattern of variation across sites. There was also some department variation within sites.

In all sites, LAs had some prior degree of involvement in health partnership or health issues, either through the presence of health units or officers in environmental health departments or through participation in HFA/HC or HOTN-type partnerships. However, LA involvement was widely reported to have increased since the introduction of the partnership agenda. As a consequence, LA resources dedicated to inter-organisational working had increased significantly, mainly composed of non-financial resources (administration and human resources). CEOs and Directors were particularly involved at the more strategic level in partnership boards. Most LAs also established (where not present) a number of internal corporate management groups or units to work on health or the HImP. SS departments were the most involved. This was followed by housing, leisure and some other community services (transport, refuse), with education generally the least involved. The degree of involvement of different departments could, however, be explained by the interplay of the different factors that shaped actors' perception of the resource costs or benefits of participation.

National agenda influences all LA departments

The national policy agenda provided the context for LA departments as it did for HAs. The large change agenda introduced a plethora of new policy initiatives and a series of re-organisational and devolutionary changes (i.e. in SS and housing). It also promoted partnership as a way to tackle health issues and social exclusion. Similar to HAs, it placed a duty on LAs to participate in HImPs, although this was not formally enacted through parliament until half-way through the study period. LAs, therefore, had to respond to a number of competing pressures, which impacted on their organisational resources. Despite some additional resources for modernisation, adherence to the previous government's spending plans meant that LAs were operating in a resource-scarce environment and many had organisational deficits. Thus, there were no core financial resources to dedicate to partnership. However, the large organisational base of LAs meant that human and administrative resource costs could be borne.

Moreover, health partnership provided an opportunity for LAs to access new resources or influence the allocation of existing resources in their favour. HAZ partnerships, in particular, offered the opportunity for additional resources for LAs. Access to additional

resources was an incentive to form partnership even though funds only amounted to 1-2% of the core budget (see Table 4.1 in Chapter 4). The HImP did not offer additional resources (at least initially), although potentially it offered the opportunity to influence local resource allocation. Meanwhile, involvement in HImP was not voluntary; there was a duty on LAs to participate. Thus, there was strong central pressure to re-organise and meet government targets while simultaneously developing lateral relations with other organisations. How did different LA departments respond to this environment?

Social Services(SS)

SS were the department most engaged in health partnerships across all sites, both HImPs and HAZ, albeit to varying degrees. Indeed, guidance at the end of December 1999 explicitly recognised the role of SS in the HImP and SaFF (DoH 1999f).

The history of working on joint issues of health and social care meant that many senior officers were familiar with the health partnership agenda. The wider health perspective encouraged by partnership resonated with their professional social model of care. Their receptiveness was helped by their experience of working with the voluntary sector. Furthermore, as there tended to be only one or two SS departments per HA district, strategic issues in the HImP were fairly congruent with their interests.

Nevertheless, the horizontal resource dependency between HA and SS meant that organisational resource interests were potentially at stake. This provided an additional incentive to engage. Countervailing the perceived benefits of engaging in partnership were the resource costs of doing so. Although the large size of SS departments meant that the administrative and human costs were easier to bear, pressure to modernise and meet government targets placed an opportunity cost on these limited resources; could they be better used to fulfil the national agenda, reducing the risk of government sanction, than for engaging in partnership? Senior SS staff were busy at the best of times, let alone when trying to implement the modernisation agenda. As a result, they were having to weigh up the costs and benefits of undertaking competing agendas.

In departments that were undergoing re-organisation or in financial deficit (3 sites), the greater focus on internal issues resulted in staff becoming more inward looking. As a consequence the balance of costs and benefits of participating tipped, leading some senior officers and their departments to pull back from engagement.

However, while the interplay of national policy, local structure boundaries and professional culture was influential on involvement in two sites, the nature of the underlying resource dependency relationship between HA and SS, coupled with the influence of key individuals, resulted in two very different scenarios between case study sites.

SS – two very different scenarios

In two sites – Dalesville and Greenshire – the degree of engagement of SS varied dramatically. In Dalesville, SS did not enter into a formal HImP partnership structure until late in the second year, although it was actively involved in the HAZ partnership and had been informally involved in the first HImP round. By contrast, SS in Greenshire was actively involved in the HImP and partnership relations were so strong between the HA and SS that a special joint commissioning unit was set up, ‘perhaps the first in England’. This discrepancy in involvement between sites can be explained by a combined influence of the underlying horizontal dependency relations and the influence of key individuals, which was unique to both sites. This is illustrated by the ‘resource base and dependencies’ box in Figure 5.1 and Figure 5.2 leaning in different directions and is discussed next.

Dalesville

In Dalesville, the horizontal resource dependency between the HA and SS appeared particularly important to SS engagement. The HA tried to engage SS, the Trusts and others in discussions over a formal structure for the HImP partnership. However, its effort was severely hindered by its attempts to concurrently change the underlying resource dependence relationship between the HA and SS. The HA was under central pressure to close its long-stay care beds for older people, create some intermediate care

beds and move people into community care, for which SS had responsibility. Unlike other study sites, the number of care beds in Dalesville was around 400, more than ‘the rest of the world put together’. Moving patients into the community would reduce resource costs for the HA but impose a resource burden on SS and Community Trusts. The resources at stake for SS were significant, especially as the organisation was in financial crisis and operating in a resource-scarce environment. As the Director of SS noted:

“[There’s] a lot of complex issues which arrive out of that, like, how do you share risks, or do you share risk, or do we say no, the risk is all yours funding agency? How do the health authorities cap their financial liability, how do we deal with issues like the replacement population?”

Indeed, SS had recently undergone a restructuring to address its financial deficit. Table 4.6 in Chapter 4 shows the NHS Executive’s recurrent allocation adjustment for old long-stay placements paid to HAs, some of which could be used to support the transfer of older people into the community. The difference between Dalesville and other HA districts of similar budgetary magnitude was ~£5 million pounds. It took the HA over 18 months to negotiate with SS the criteria for funding placements in the community. During this period there was a reported lack of transparency over financial issues between the HA and SS at both county and unitary levels, and the HA was actively monitoring the minutes of council meetings so as to identify any financial manoeuvres which might have had implications for the HA. Tension between the HA and SS was heightened by the presence of a key individual, the HA CEO, with a strong, forceful personality who was difficult to work with. Furthermore, the LA was perceived as ‘traditional Labour’ and ‘backward’ with many members wedded to old ideas on care for older people. Councillors echoed the concerns of a few vociferous members of the public. This tipped the ‘resource base and dependencies’ box in Figure 5.1 to the right, overriding the weight of the left-leaning ‘local structural/organisational boundaries’ and ‘professional/organisational culture’ boxes.

Figure 5.1. Factors influencing Social Services' level of involvement in partnership in Dalesville

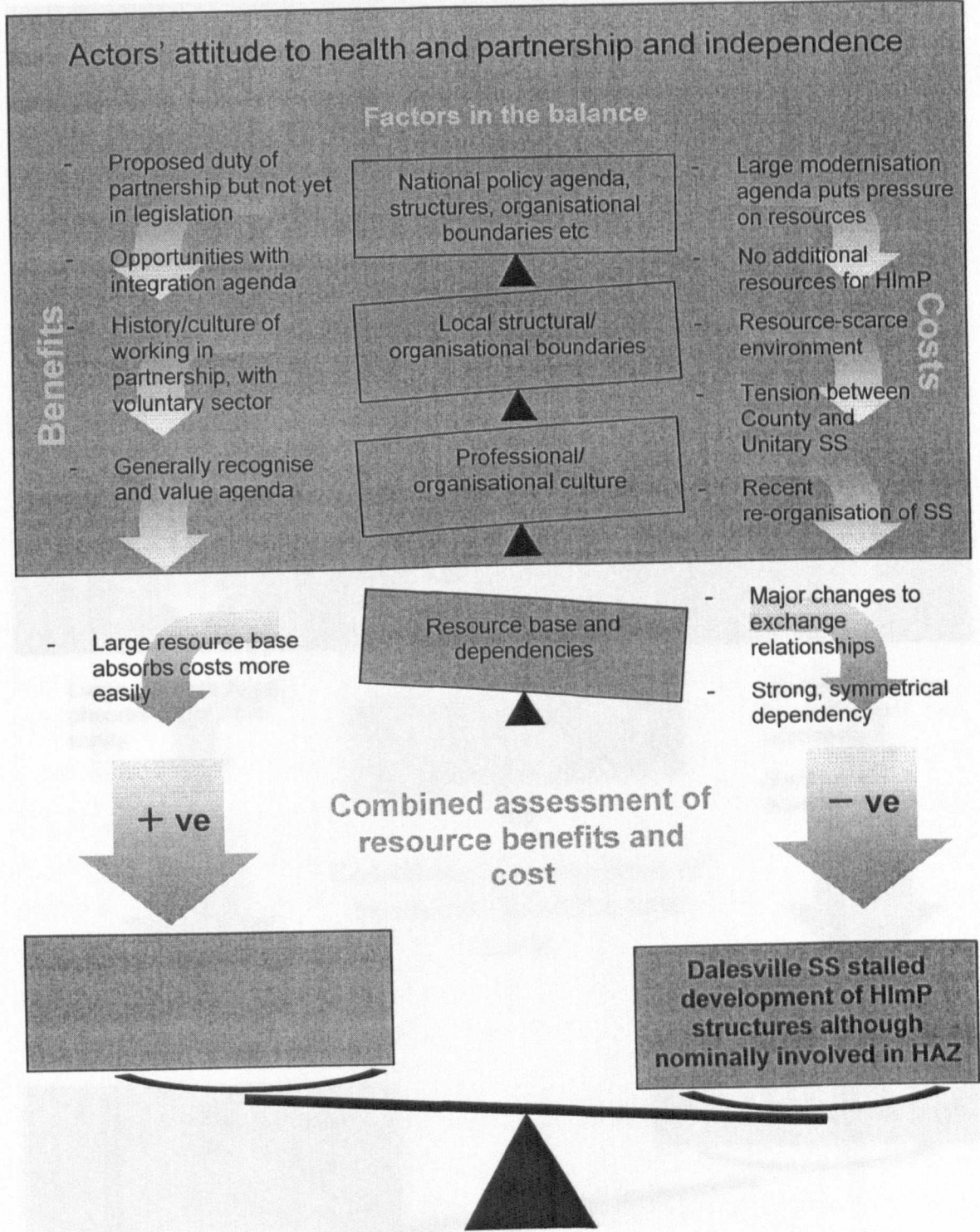
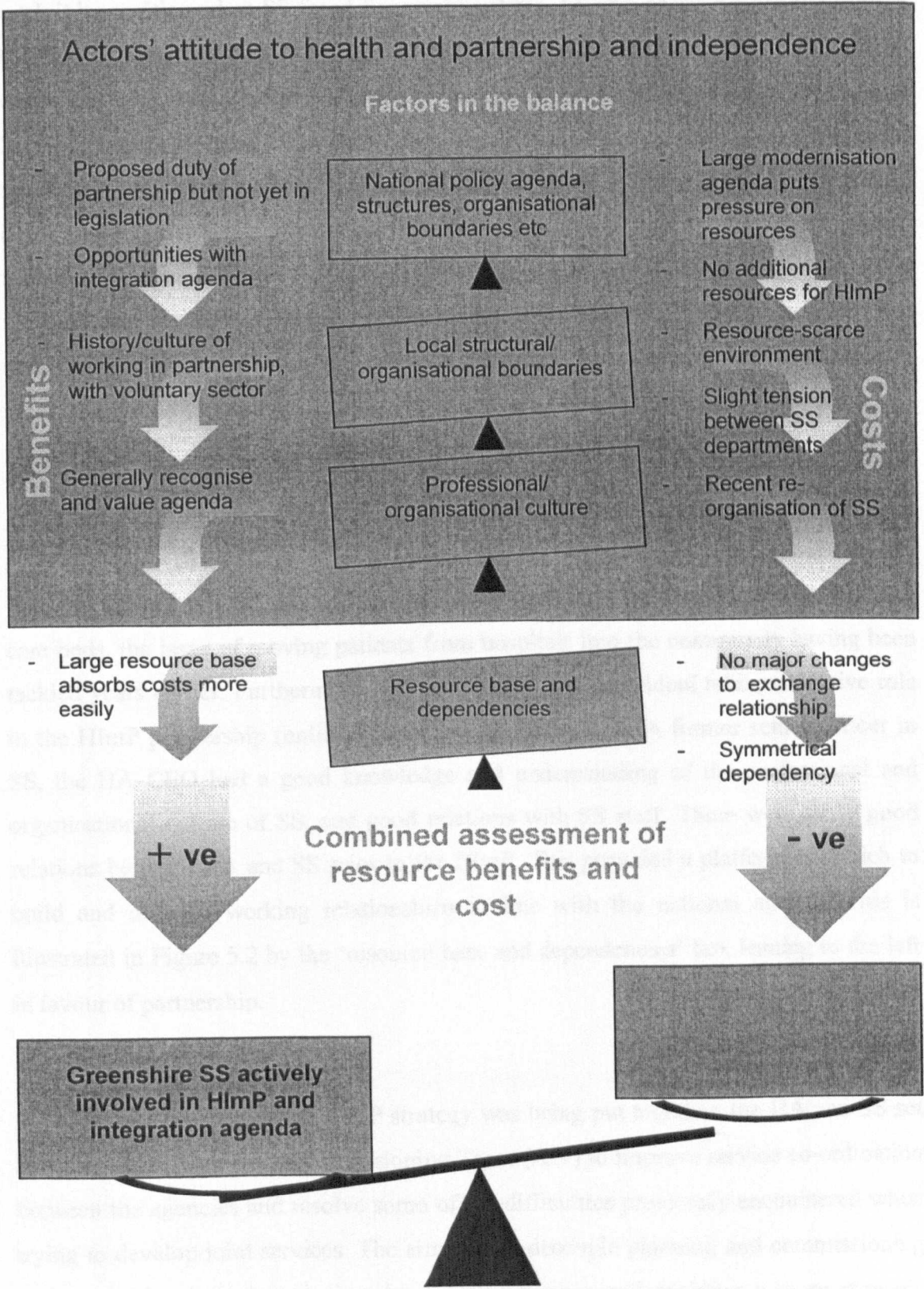


Figure 5.2. Factors influencing Social Services' level of involvement in partnership in Greenshire



The issue was finally resolved when the HA had sufficient funding to compromise with a one-off payment to SS. Over the negotiation period SS engagement in developing the formal HImP structure stalled. SS expressed fears that the HA might opportunistically exploit its position when SS faced financial hardship. SS also showed a general caution towards pooling mainstream funding. It failed to implement a joint HA and SS continuing care strategy. Final agreement on the HImP's structure was reached in April 2000. Changes to resource dependencies in a resource-scarce environment, without sensitivity, created a 'flashpoint' which led to considerable deterioration in partnership and a lack of trust between agencies. Transactional costs rose as the HA felt obliged to monitor SS's finances more closely. Nevertheless, partners resolved the issue which interviewees claimed would not have happened 'under the former regime and arrangements'. The right-leaning 'resource base and dependencies' box returned to a more even keel and the overall balance swung down to the left in favour partnership.

Greenshire

In Greenshire (like Middleton and Metrocity), the resource dependency relationship between the HA and SS was smaller and more stable. There were far fewer long-stay care beds, the issue of moving patients from hospitals into the community having been tackled years earlier. Furthermore, HA CEO was a key individual taking an active role in the HImP partnership (unlike Middleton and Metrocity). A former senior officer in SS, the HA CEO had a good knowledge and understanding of the professional and organisational culture of SS, and good relations with SS staff. There were fairly good relations between HA and SS prior to the HImP. This provided a platform on which to build and develop working relationships in line with the national agenda. This is illustrated in Figure 5.2 by the 'resource base and dependencies' box leaning to the left in favour of partnership.

At the same time as the first HImP strategy was being put together, the HA and SS set about establishing a Joint Commissioning Team (JCT) to improve service co-ordination between the agencies and resolve some of the difficulties previously encountered when trying to develop joint services. The aim was to decouple planning and commissioning from operational work, reducing day-to-day pressures and enabling a more strategic

view to be taken. On 1 April 2000, after 12 months of ‘complex negotiations’, the JCT came into operation. Based in the HA, it brought care teams from each agency under one system of accountability, with ‘responsibilities that transcend SS and the health boundary’ enabling joint planning but without pooled budgets. Headed up by the Assistant Director of SS (a joint appointment) and an Executive Director of the HA, it was accountable to the Joint Partnership Team (JPT), an informal body of LA members and HA non-executive directors outside the formal HImP structure. The JCT led to ‘very much closer co-ordination between HA and SS’ and to franker exchange of sensitive financial information and development work to share information on individuals. Its development required a ‘good deal of trust’ between senior officers and members, as it shifted the management of joint planning away from the SS (who were previously primarily responsible) towards the HA. The HA CEO noted that even against a backcloth of comparatively good partnership relations, there was a need ‘to win people over [...] to demonstrate, really, by examples, [...] the value of partnership.’ While the JCT did involve a small loss of autonomy over allocation, primarily for SS with its larger budget, closer integration presented an opportunity to improve the co-ordination and quality of social care services.

However, in developing the JCT, the HA and SS did not involve other agencies such as housing, education or the voluntary sector, showing some degree of ‘narrow thinking’. Furthermore, closer working between the HA and SS in the JPT made other partners feel more excluded from decisions over financial resources in relation to joint care groups, particularly as some partners (such as Probation, CHCs and the voluntary sector) moved from the former JCC structures on to HImP partnership groups where decisions about financial allocations were not made.

Community services (Environmental Health, Housing and Leisure departments)

Community service departments such as environment, housing, leisure (often grouped together in study sites) were significantly less involved in HImPs than SS. These departments were located in district or unitary councils. There was limited involvement in the upper tiers of HImP and HAZ structures, particularly in HAZ sites, and on the whole these departments were more active at the operational or policy development

level. Despite all sites having LAs with a tradition of working on health issues, usually through health units based in environmental health, these departments had a historically lower base of involvement in health partnership, with only middle ranking officers attending HFA/HC partnerships who took an operational rather than strategic focus. Some officers still saw their role in terms of enforcement, and health as an NHS issue. However, over the two years, in all but Metrocity these departments became more involved in strategic planning, either through the HImP board, or the beefed-up HFA structures. The commitment of the housing department to joint working was the weakest of these departments in all sites, and in two sites, they were reported to be taking less of an interest than in previous partnerships. Housing officers tended to hold a narrow, medical view of health.

How can the difference in engagement be explained? Again a different combination and weight of factors outlined in Figure 4.1 in Chapter 4 can help explain a general pattern of involvement but also the pattern within study sites.

As with HAs and SS, the large national policy agenda placed pressure on resources. Departments were expected to respond to the intra-organisational agenda on modernisation while engaging in the inter-organisational agenda on health. There was only a moral obligation on LA departments to do the latter as the legal duty had not received parliamentary approval. Furthermore, DoH guidance on *Planning for health and health care* did not explicitly recognise the role of LA departments besides SS in HImPs and SaFFs (DoH 1999f). However, these departments were also operating in resource-scarce environments. Thus, community service departments were also under human and financial resource pressures. Staff were busy with the national agenda while simultaneously under pressure to get involved in resource-consuming partnerships. The cost-benefit analysis therefore worked against their involvement. As one DC CEO commented:

“I’ve got a duty to look at health partnerships, a duty to look at community safety partnerships, a duty to look at you know, any number of things, but there are only so many hours in the week. And I’m not one to turn my back

on any of these things, but you've got to prioritise, and you go to any of the district councils up and down (Greenshire Health Authority), and you'd find very different views on how committed they are to this."

In contrast to SS departments, officers in community services were generally less able to identify with the national agenda on health partnership and could not appreciate the relevance of the agenda, or see how their organisation would contribute or benefit. However, this could vary within and between sites.

As the HImP did not offer access to additional resources, the cost of involvement was heavy on officers' minds, and was being weighed against other priorities. The slightly smaller resource base of DCs meant they were more sensitive to human resource commitments than larger departments.

Even in DCs that understood and were committed to the agenda, departments were having to 'draw back' on their commitment of human resource to partnership. Some were not attending as many meetings or groups as they would have liked and were forced to prioritise their efforts to attend what they perceived as key meetings, when an agenda item was particularly relevant. EHO involvement in Home Safety and health inequalities groups, for example, suffered as a consequence. In general, less senior representatives were sent to meetings with less authority to make decisions.

Organisational boundaries could also influence the way in which individuals perceived the relevance of a HImP strategy to local interests. In rural sites, there were more DCs, each with divergent interests. Where local issues were not addressed by the HImP strategy, this could reduce the perceived benefits of involvement, tipping the cost benefit calculation in favour of withdrawal.

The cost-benefit calculation was further complicated by local organisational structures, local politics and the influence of key individuals, as discussed in Chapter 4.

Two different scenarios within a district

These factors could also combine within sites to give very different levels of engagement. A good example of this was in Greenshire, where the level of DC involvement varied dramatically. One centrally located DC was actively engaged in the HImP partnership, leading a HImP sub-group on inequalities. This was in marked contrast to a DC in another area, which was on the verge of disengaging from the HImP process. How the combined weight of these factors influenced involvement is illustrated in Figure 5.3 and Figure 5.4.

District A had a key individual, the CEO, who had a systems view of health and could relate to the agenda. There was also some degree of political support for involvement. The DC was ‘champing at the bit’ to get involved and willing to contribute resources to support the process. This is depicted by the ‘local structural/organisational boundaries’ and ‘professional/organisational culture’ boxes leaning to the left. However, District B was at the margins of the county boundary and could not see the relevance of the strategy agenda to local issues. Furthermore, there was no political support. In Figure 5.4 the equivalent boxes leaned to the right. With a weak resource dependency relationship between DCs and HAs, there was little compulsion on District B to engage in the HImP (indicated in Figure 5.4 by the scales tipping to the right) as the costs outweighed the benefits. District B withdrew.

Nevertheless, even District A was very conscious of the costs of involvement. An impending financial crisis and pressure from LA members made the CEO re-consider his commitment to the partnership. Despite being aware of the benefits of partnership, the costs of involvement were considered too immediate and high, especially when opportunity costs were about limiting staff redundancies. Self-interested organisational priorities took precedent. As the DC CEO commented:

“[There are] 44 posts. The proposal is to reduce those by 14, with voluntary redundancies. I mean pressures like that, you have to look at what’s the knock-on effect on things like partnership working. How much time can you give?”

Figure 5.3. Factors influencing Environmental Health's level of involvement in partnership in District A, Greenshire

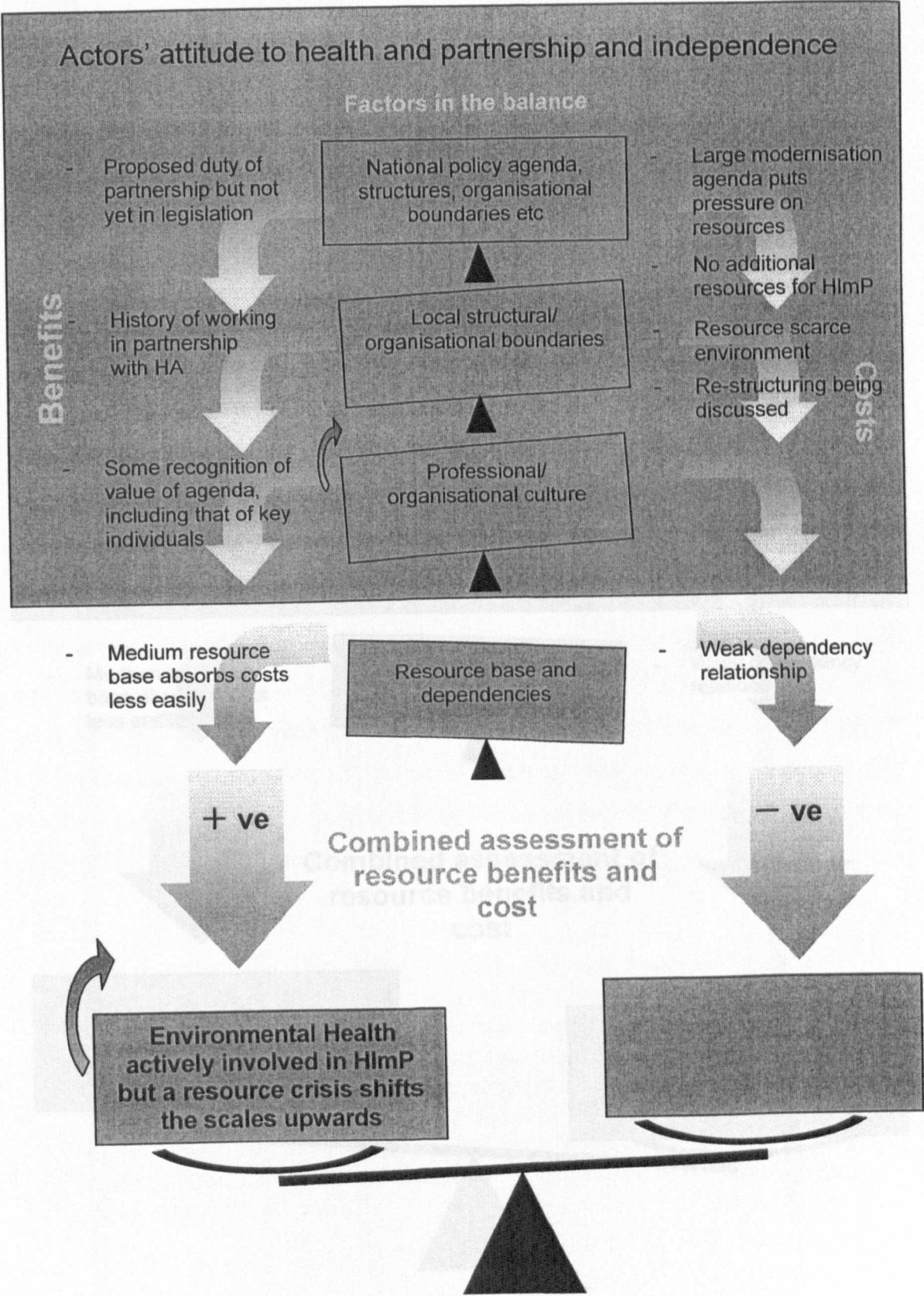
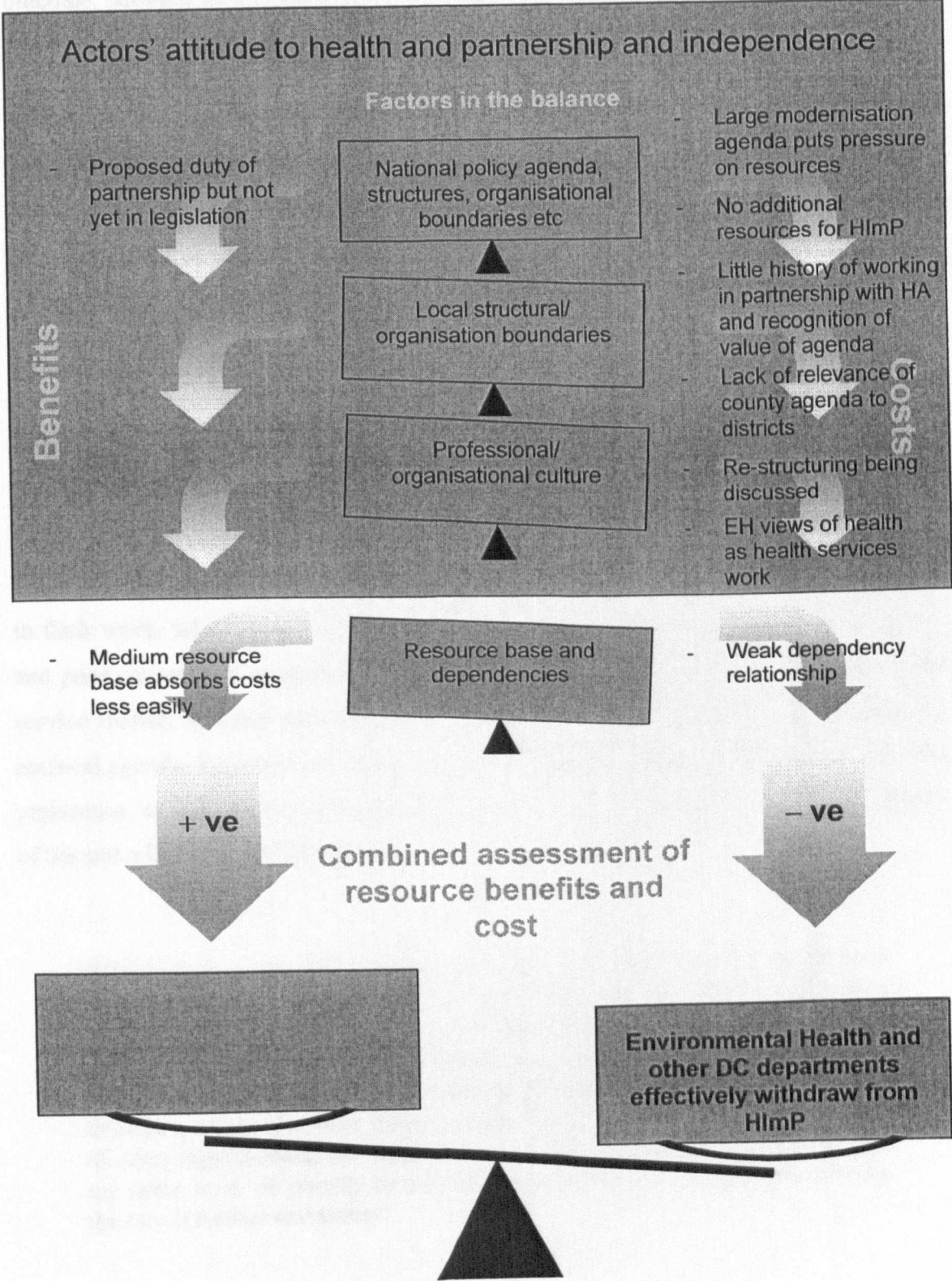


Figure 5.4. Factors influencing Environmental Health's level of involvement in partnership in District B, Greenshire



A number of members and senior officers expressed similar sentiments, even those who understood the health partnership agenda. There was increasing concern as time progressed that too much resource was going into meetings without evidence of any outcome. Moving to this more tentative position is illustrated by the arrows in Figure 5.3.

Key individuals in housing and other departments, as noted in Chapter 4, generally had a narrower perspective of health and were less tolerant to the slow delivery of outcomes, and more likely to withdraw from partnership.

Education

Education departments were generally the least involved LA department in health partnerships (HImPs and HAZs), particularly at the strategic level. Only in Greenshire was the education department represented at the HImP Board by senior management (Assistant Director), although there was some representation in more operational groups elsewhere. Senior educational officers could not see the relevance of the health agenda to their work, which was about educational attainment. The link between poor health and poor educational achievement had not been made. Health was very much a health service matter, and any participation was considered a distraction from achieving the national agenda. Priorities from their respective government departments tended to take preference, as indicated by this extract from a reported conversation between a Director of SS and a Director of Education.

“[I]f there is a potential conflict between allocating resources which have direct educational impact and allocating the same resources so that they have a health impact but lower educational impact, then I’m more likely to give priority to the educational impact than I am to the health impact. That may then be perceived as not being committed to the health agenda and, therefore, we need to have a more sophisticated way of judging the activities of other organisations by whether or not those organisations are able to give the same level of priority to what health organisations would see as being the key activities and tasks.”

5.2.3 Trusts

Acute and Community Trusts were generally less involved in HImP and HAZ partnerships than most LA departments. Involvement in partnerships was at strategic and programme groups and included senior managers, directors or consultants but rarely CEOs. Community Trusts tended to be more involved in health partnerships than Acute Trusts and many had direct links to LAs or had been involved in HC/HFA partnerships. This contrasted with Acute Trusts, which as providers in an internal market, had generally been excluded from the joint planning machinery during the 1990s.

Despite a statutory duty on Trusts to be involved in HImPs, individual Trusts likewise seemed to be making similar cost-benefit calculations of involvement.

HImPs did not have a budget; the allocation of resources to Trusts was discussed in the SaFF group, in some cases loosely linked to the HImP structure. Involvement in the HImP, unlike the SaFF, therefore did not have any resource-related implications for Trusts, besides those attached to participating in the process.

In some study sites, the potential influence of the HImP on Acute Trust resources appeared to be weakened further by the nature of the underlying horizontal resource dependency relation between the HA and the Trust. Some urban Trusts, for example, had access to additional resource streams through their research programmes and contracts with neighbouring HAs, reducing their dependency on their local HA, and therefore, reducing any potential threat to their interests from involvement in partnership.

Furthermore, the dominance of a narrow, medical perspective on health, particularly in Acute Trusts, meant actors had difficulty in appreciating the relevance of health partnership to the Trust's agenda or understanding the benefits of participation. A number of respondents reflected this view, considering their contribution small. The overall impression was that:

“[Within] Trusts, there is very much a [...] defensive attitude to [...] protecting your own corner and protecting your own resources.” Assistant Director, HA

The shift in policy towards a health service agenda (waiting lists, A&E etc) coupled with the strong central pressure to deliver, played to this narrow, self-interested perspective. Busy senior staff had to weigh up the opportunity costs of involvement in partnership against delivering this agenda, and the potential consequences of failing to do so. The latter threatened organisational autonomy and resources. Furthermore, government pressure on Trusts to reduce outstanding debts also increased their sensitivity to the resource implications of participation. This sensitivity to costs was typified by one Director of an MH Trust who expressed indignation that the HImP Co-ordinator had asked the partnership board for more administrative support [Field notes] when they and other partners such as the voluntary sector had to bear the costs.

While these factors combined to deter actors from engaging in the HImP partnerships, in the two HAZ sites, Trusts were voluntarily involved in HAZ partnerships, despite the pressures on organisational resources. However, involvement in HAZ partnerships appeared to be driven by the need to access extra resources rather than a commitment to, or understanding of the health partnership agenda. Trusts were perceived to be more engaged in the agenda when financial issues were being discussed. As one DPH commented:

“Trusts will sit there and doodle, and say really, this hasn’t got a whole load to do with me, until we get onto money for coronary artery bypass grafting, and then they wake up and say give it to me.”

5.2.4 Health partnership and control over financial resources

Resource Dependency Theory argues that organisations in partnership manipulate exchange relations in their favour, seeking to increase access to resources whilst limiting losses to autonomy. However, behaviour is also dependent on the symmetry of dependency relations. Mutual dependence can either provide conditions ripe for resource exchange and activity co-ordination, or it can result in mutual vulnerability,

where organisations limit their areas of resource exchange so as not to upset each other (Scharpf 1978). This section considers the nature of resource exchange between large, symmetrical resource-based organisations in health partnership in order to identify whether organisations were seeking to increase exchanges or whether they were content remaining with existing dependency relations.

While HAZ and to a lesser degree HImP partnerships provided organisations with the opportunity to access additional financial resources – an incentive to participate when resources were tight – in none of the study sites did these partnerships acquire control over mainstream budgets. In HImPs, control was not even ceded over additional ring-fenced monies.

Allocating mainstream organisational budgets to HImP or HAZ partnerships was either rejected by partners or considered as inappropriate at this stage in the partnership's development.

To do so would have required the statutory bodies to untangle the elaborate lines of accountability and the close involvement of LA members and non-executive directors in developing the partnership structure, as these individuals may have resisted such developments.

Although such individuals were involved in the joint planning structures (accountable for JF monies), only in Metrocity did they get more involved in the health partnership (HAZ). This was not only to provide a coherent link with the joint planning structure but also to help ensure successful HAZ projects were mainstreamed. Nevertheless, in three sites (Greenshire, Dalesville and Metrocity), the HA was working on notional resource assumptions for the HImP, based around care or illness groups rather than organisational provision, with a view to aligning service and financial planning under one framework, in line with HImP guidance on Long Term Service Agreements (LTSA's) (DoH 1999f). One HImP Co-ordinator put it:

“[L]inking resources to agreed priorities, yes I mean I think that’s what we know that we haven’t done. I mean the excuse would be that we’ve been busy putting the system together. The reality is that we don’t want to trust the partnership too soon before it really got going, we would want, I guess, to have it a bit firmer and stronger and more robust that it can handle some of these difficult issues.”

Therefore, organisations retained responsibilities as sovereign bodies for their own core resources. Although discussed and debated, formal joint accountability for mainstream organisational resources was not on the cards. Rather, it was widely accepted by respondents from all sectors that HImP and HAZ partnerships were about influencing organisations. HImP partnerships were advisory bodies which, through development of the HImP strategy, aimed to influence how partners developed their services and allocated resources. Compliance with the strategy was to be through group pressure. However, the mechanisms to undertake monitoring were barely developed in all sites.

Local control over HAZ resources was reduced by government ring-fencing of funds and its changes to the requirements of its performance management regime, as shown in Chapter 3. Commitment to mainstreaming successful HAZ projects was undermined by the nervousness amongst SS departments about their resource deficits [Field notes].

Small additional monies received by some HAs were allocated by HImP partnerships. However, former JF monies and specific grant funds were placed in the control of Health Social Care Boards which operated in parallel structures to the HImP, and initially at least, gave few if any voting rights to the voluntary sector.

Indeed, control over health care resources allocated through horizontal dependencies from the HA to Trusts or SS resided in the SaFF and JIP. These agreements/plans were negotiated in groups which, on the whole, had restricted membership (mainly to HA, Trusts, PCGs and SS) and were located at the margins of the HImP structure or beyond it. Although government policy and guidance identified the HImP strategy as driving the direction of resource allocation in these groups, in reality this was not the case.

SaFF

On the contrary, the SaFF drove the whole expenditure plan in all sites, despite the desire by NHS regional offices for SaFFs to be developed within the context of HImP. The tight timetable imposed by central government meant that the Director of Finances from member organisations was largely responsible for decisions. The close time-tabling of HImP and SaFF planning cycles, as specified in guidance (DoH 1999f), also weakened the ability of the HImP to influence the SaFF. As a consequence, the direction of investment in health services was effectively determined by national priorities like waiting lists, cancer waiting times and financial balance, and availability of cash in the HAs. Trusts were given money but it was 'badged' to deliver these priorities. Discussions focussed on resources and activity rather than broader issues around health promotion or transport etc. After national priorities, the SaFF allocated resources to services that were desperate for investment or 'falling over'. Finally, if there were residual resources, these were allocated for planning on a rational basis (i.e. based on local needs assessment) and might include health improvement. Only the late unannounced injection of government money at the end of the second HImP allowed room for manoeuvre in this allocation hierarchy.

JIP

Similarly, JIPs were introduced to get HAs, SS and other stakeholders to jointly agree the allocation of resources for developing health and social care service (DoH 1999f). JIPs were initially required for OP and MH (adults) services. A third was proposed for LD. However, JIPs did not immediately link with the HImP agenda as envisaged in government policy and guidance. Indeed some partners saw the JIP in isolation from MH NSF implementation. Pooled budgets were discussed and debated, but in no study sites had the HA or LA established 'pooled budgets'.

“[P]eople always talk about the necessity for an identified pooled budget, people are always very keen on that, very supportive of it, in reality it hasn't tended to happen yet.” Manager, HA

Even in Greenshire where HA/SS relations were very good, pooled budgets were not developed. As the HImP co-ordinator noted:

“If we can’t do that [here] then who will be able to?”

In other sites, despite some talking up of pooled budgets and use of freedoms, there was perceived to be reticence and suspicion from SS, with officers being ‘unambitious’ and ‘holding what they have’. In some sites, resistance was attributed more to councillors. As one Director for a Community Trust noted:

“[I] think it basically seems too radical to pass over control in that sort of way.”

Table 5.1. Degree of HA and SS integration in the management of Mental Health, Older Peoples and Learning Disability services by study site

Study site	Mental Health	Older People	Learning Disability
Dalesville	Working on integrated provision and commissioning through SDGs linked to HSCB	Working on integrated provision and commissioning through SDGs linked to HSCB.	Working on integrated provision and commissioning
Greenshire	Integrated (strategic (JCT) and some operational (drugs team))	Integrated (strategic (JCT) and some operational level)	Integrated (strategic (JCT) and some operational level)
Metrocity	Some areas/service CMHS i.e. joint locality managers & teams, with joint accountable to the CT and SS	Initial discussions afoot. Some co-ordination of resources on specific pieces of work i.e. crisis Outreach Teams. Talks on integrated management in intermediate care	Based in SS
Middleton	Working on integrated management and multi-disciplinary teams CMHS	Expressed commitment. Work on single assessment and care management	Integrated
National survey ¹	42% (joint provision & commissioning)	22% (joint provision & commissioning)	33% (joint provision & commissioning)

¹Local Government Association (2000)

Key

SDG – Service Development Groups
HSCB – Health and Social Care Board
CMHS – Community Mental Health Services
CT – Community Trust
JCT – Joint Commissioning Team

Nevertheless, between the HA and LA, and in line with the government's modernisation agenda, there were some moves to integrate management of MH, OP and LD services, albeit to different degrees across all sites. This showed a willingness to work together more closely in well-defined areas, as indicated in Table 5.1. A survey by the Local Government Association (2000) suggested a similar picture around the country, with nearly three-quarters of LAs (excluding DCs) having joint commissioning or management arrangements but few sites extending these flexibilities to pooled funding.

Some links between the HImP and SaFF and JIP were reported by Carruther (1999) although the degree of HImP influence over SaFF and JIP was not discussed.

5.2.5 Summary of section

In Part 1 of this chapter it has been shown how the factors identified in Chapter 4 combine in positive and negative ways to shape general patterns of engagement in health partnership in three types of organisation: HAs, LAs and Trusts. It was shown how these factors combined in unique ways within sites resulting in varying degrees of involvement, for example, of SS and DCs. Recognition of the need to take a partnership approach and the perceived benefits of doing so were countered by concerns about the organisational resources required for engagement in a resource-scarce environment in which government spending plans and policy initiatives demanded organisational resources elsewhere. In line with the assumptions of RDT, actors appeared to be making cost-benefit calculations over involvement in partnership.

The provision of additional funding appeared to provide an incentive even for organisations, which, in general, held a very narrow, medical view of health, such as Acute Trusts. However, involvement did not mean that such organisations were attuned to tackling the health agenda. Involvement seemed to be driven by self-interest rather than 'mutual benefit'.

Aside the availability of relatively small sums of additional monies which attracted HA, Trusts and SS into HAZ partnerships, these organisations did not appear to be

manoeuvring to increase their access to other organisations' financial resources or reducing their resource dependencies on other organisations, as a crude interpretation of Resource Dependency Theory might predict. There also appeared to be a reticence to relinquish control or autonomy over mainstream budgets by placing it in the control of HImP partnerships. Pressure to reduce resource deficits in a resource-scarce environment resulted in a degree of caution amongst partners (SS/HAs) about jeopardising organisational finances. Essentially, the partnership arrangements in all sites maintained existing resource exchange relations, even where partnership arrangements and relationships were well developed, as in Greenshire. However, there was some willingness to move to closer working and integration of human resources, through joint management, the sharing of informational resources and co-ordination of budgets, even if accountability, and therefore control, over financial resources was not relinquished. In exchange for access to these non-financial resources, they accepted a small loss of autonomy over service provision.

The exception to this was in Dalesville, where the HA, under pressure from central government, attempted to change the underlying exchange relationship with SS by relinquishing much of its control over a care group and some of the resources attached with it. However, SS were concerned that such a change might unfairly shift costs onto their organisation, costs which it could not afford to bear. Thus, although such a move would have increased organisational resources (service provision), it also threatened its financial interests. The consequence of disturbing the underlying resource dependency relationship and endangering SS's core resource base was to stall the development of the formal HImP structure.

In general, a situation of mutual vulnerability appeared to exist, in which partners appeared willing to work in areas or 'zones' which were accepted as legitimate (Scharpf 1978). The development of integrated management and, in one case, a joint planning unit could be construed as such a 'zone'.

While HImP partnerships did not result in a loss of control over organisational resources, involvement did have resource implications for organisations or carry a

potential threat. The degree of involvement seemed to be functionally dependent on the balance of these perceived costs and benefits. Given their vertical demands, organisations appeared to be particularly concerned with minimising the resource cost of involvement.

However, the degree of involvement of organisations with a smaller resource base and more asymmetrical dependency relations appeared to be guided by slightly different considerations, as Resource Dependency Theory would predict. These are discussed in Part II of this chapter.

Part II

This part of Chapter 5 considers the nature of horizontal relations between organisations with a small resource base, namely the voluntary sector, PCGs and other small statutory organisations (i.e. CHCs). At the beginning of this chapter, it was noted that the degree of involvement and engagement of small resource-based organisations appeared to differ from that of large statutory organisations. How and why it differed will be explored in the remainder of this chapter. Indeed, it will be shown that although involvement in partnership for these organisations was either voluntary or mandatory (i.e. for PCGs) depending on the organisation, motivation to get involved in partnership appeared to be similar. While actors appeared to be weighing up the costs and benefits along the different dimensions in Figure 4.1 in Chapter 4, two dimensions in particular appeared to influence the behaviour of actors and the nature of inter-organisational relations: small resource-base and asymmetric resource dependencies. Organisations with a small resource-base and moderate to high dependency on HA and LA resources or *unilateral dependence* (Scharpf 1978) appeared to enter into partnership, despite not having the organisational capacity to do so. In accordance with RDT, actors appeared to be motivated by the need to seek or stabilise resources or fear of jeopardising underlying exchange relationships. However, despite a high degree of involvement, the voluntary sector felt that it had little influence and this related to its weak financial resource base.

Part II begins by considering the motivation of the voluntary sector, PCGs and other small resource-based organisation for getting involved in partnership, and then moves to consider the degree of influence these organisations had over policy development and resource allocation in health partnerships.

5.3 Health partnership as an opportunity to access or exchange resources?

5.3.1 Voluntary sector involvement - actively seeking resources?

The voluntary sector was actively involved in both HImP and HAZ partnerships in all sites, although there were variations within and between each site. Most notably, there was an increase in voluntary sector involvement in health partnership across sites, particularly in the HImP and HAZ partnerships as their structures were developed.

At the strategic level of HImP and HAZ partnerships, umbrella voluntary organisations were primarily involved. By contrast, single-issue voluntary organisations and user and carer groups tended to be involved at the tactical or operational level as well as in JSG/JCC structures where these still existed. A community representatives group was established in one site (Metrocity) but its membership mainly consisted of voluntary organisations and area-based organisations, not community groups. While community-type area-based groups such as neighbourhood forums, some with health action groups, were present in most sites, these groups did not have a direct link into the HImP and HAZ partnerships. Broader public engagement was not well developed in sites, and with the exception of one site where the LA had developed citizen panels, views were sought with surveys/questionnaires.

Moreover, despite significant voluntary sector involvement and an expressed desire by statutory sector respondents to include the voluntary sector in line with DoH guidance, there was no evidence of a systematic or strategic attempt to involve the sector in health partnerships, a finding reported in other HAZ sites (Barnes, Sullivan et al. 2001). Arrangements were often left to partnership sub-groups to determine *ad hoc*. Thus, voluntary sector involvement tended to follow set historical patterns whereby groups already in contact with HAs and LAs were often those with which new arrangements were made. Although several HAs (in non HAZ sites) had commissioned mapping studies to establish where the voluntary sector was involved with HAs and LAs locally and how its representation could be increased, this was not part of a wider strategy. The surveys themselves suggested that HAs and LAs were only engaging a small fraction of voluntary sector organisations working on health issues (if a broad definition was used) [Field documents].

Nevertheless, the voluntary sector seemed fairly involved even though, unlike the statutory sector, involvement in HImP partnerships was voluntary. Similar to the statutory agencies, resource issues lay at the heart of the voluntary sector's involvement in health partnerships.

National agenda

Although the national agenda did not apply directly to the voluntary sector, indirectly through guidance (DoH 1998j) it did encourage statutory agencies to include the voluntary sector in HImP and HAZ partnerships. Indeed, HA and LA guidance for HImPs, SaFFs, JIPs and PCIPs (DoH 1999f) (and area-based initiatives) stated that the voluntary sector should be involved to reflect the health needs of the local community (DoH 1999f). Following the Health Act (1999) further guidance explicitly recognised that HAs could transfer funds from HAs to the voluntary sector via LAs in order to provide or commission services which supported the objectives of the HImP (DoH 2000d). Such service transfers would be subject to Best Value review (DoH 2000e). The national agenda also influenced the voluntary sector simply because it was moderately resource dependent on statutory agencies. Most of the resources received by the voluntary sector were from the statutory sector, particularly from the HAs and SS departments. However, as noted already, statutory agencies were operating in a resource-scarce environment with many under pressure to reduce outstanding financial deficits. Consequently the resources they could provide for the voluntary sector were also tight.

In the study sites, the voluntary sector was largely funded for the provision of specific services. Funding did not cover core organisational activities. Furthermore, funding levels were generally low and resources tight. Many groups were operating on a 'hand to mouth' existence. This was exacerbated by funding structures based on short-term contracts which often led to uncertainty (as continuity between contracts was poor and fragmented), and inefficiency (as multiple organisations competed for small sums of money, expending much effort in the process). This was in direct contrast to resource dependency structures for the large statutory agencies which were fairly stable. As a consequence, there was little resource available to support the voluntary sector's involvement in partnership. Releasing staff to work in health partnerships, an activity

for which many voluntary organisations were not paid, was difficult. There simply was not the organisational capacity to do so.

The tight timetable for health partnership set by the government further increased the amount of resources required for the process. However, the level of organisational capacity was not homogenous within or between study sites. Capacity, for example, seemed to depend on the history of partnership working in the area. The resources available to the voluntary sector could also be influenced by local politics and politicians. In Metrocity, the political programme of the newly elected party was to cut costs, and financial support to the voluntary sector was a prime target. This further undermined the sector's resource stability and base.

How did the voluntary sector respond to HAs' requests to engage in partnership? Despite the lack of resources, many in the voluntary sector were eager and willing to take up the invitation, even though capacity limited their ability to get involved in as many partnership sub-groups as they would have liked. Indeed, in all sites the voluntary sector was pressing for greater representation in health partnerships:

“The voluntary sector pushed at an early stage to double their representation, and that's where there's been more disagreement than agreement.” Assistant Director of SS

Many in the voluntary sector actors recognised their contribution to partnership in positive terms – providing ‘expertise and knowledge’, information on ‘hard-to-reach’ clients, picking up cut statutory services or presenting ulterior perspectives – but still did not consider they were receiving sufficient funding to fulfil this role adequately. Nevertheless, involvement in partnership provided a potential source of new resources (especially HAZ partnerships).

The statutory sector, for its part, was motivated to involve the voluntary sector in partnership because of its expertise and information (although such benefits were ‘not appreciated at times’) but also because voluntary sector involvement was required by

central government. As statutory agencies were heavily dependent on central government for resources, particularly HAs (and to a lesser degree LAs) there was a strong obligation to comply with central demands, as shown in Chapter 3. Not to do so risked jeopardising their financial position.

In all sites, HAs or health partnerships had made resources available to support involvement (using former JF or HAZ monies) although they were not available to all voluntary sector organisations which were or wanted to get involved.

Many voluntary organisations with a well-developed resource base and a strong relationship with the statutory agencies, for example, through the establishment of Compacts, had negotiated resources for attending partnership meetings. These organisations tended to be those relating to the joint planning care groups (i.e. MH or Physical Disabilities) or umbrella groups which had received long-term financial support through JF, for example, and had therefore been able to develop good networks.

In general, the voluntary sector in all sites did appear to be acting to maintain or increase its resource base, or gain other advantages, as long as it did not threaten its interests as predicted by RDT.

“I’ve discussed it [involvement in HAZ] with the trustees of my agency and my senior staff because, obviously, as the director, I’ve got lots of other things I should be doing too. But the agency has made the decision that as the agent it’s not our altruism after all that the agency will gain by taking a slightly higher profile for a couple of years.” Director, VS

Involvement in partnership also offered the opportunity to influence local strategy and policy towards the voluntary sector viewpoint.

Others seemed to be motivated by a perceived threat to their interests if they did not participate. Government changes to Joint Finance - a major source of voluntary sector funding – together with the potential demise of the JCC, no longer a statutory

requirement, created anxiety amongst some organisations. Confusion over the new health partnership arrangements fuelled this apprehension. Furthermore, the JCC was where the voluntary sector traditionally had a link with councillors and therefore some influence.

“I think there’s been a sort of worry, within the voluntary sector, about potential loss of influence [...] we still have a Joint Consultative Committee in Greenshire, but there’s a sort of wondering about where it’s going to go, what’s its future going to be?” Assistant Director of SS

Confusion and concern was also heightened by the creation and development of the PCGs, which potentially changed the arrangement for planning and commissioning and the location of grants.

Across all sites, there was a perception that the driving force behind voluntary sector involvement was a fear of loss of resources, as the following comment indicates:

“I think the only reason that they [the VS] got involved was because they were very threatened by it. They also perceive the health alliance as a multi-agency thing that was going to set up projects, and they felt that that was what their role was [...] because they felt that if they didn’t get involved it might run away with their jobs.” Manager, HP

And, yet, conversely, involvement in partnership came at a cost for the voluntary sector. Even with additional funding from statutory agencies to support engagement, many organisations still complained that they did not have sufficient capacity to support the demands of partnership and pushed for more resources to support the sector.

“I’ve got a number of disabled people who are chairing those groups who have no admin support, and who are floundering a little bit and not particularly happy chaps...but they are struggling to keep it going, whilst I continue to talk with the Joint Commissioning Team and so on, about how this admin support is going to be provided to them.” Director, VS

In Middleton, for example, a long-established voluntary organisation had to weigh up the value of partnership against the cost of involvement. As the Director noted:

“I get very active if there’s something in it and it can help our clients [...] but it’s also the time commitment to things like that [the HImP].”

Indeed, in Greenshire, one organisation which had developed a Compact with the HA and SS, refused to take on a lead role in the HImP unless the HA gave resources to support the director’s involvement, which it did. Weighing up the costs and benefits of engaging in partnership, he was well aware of the conundrum of short-term financial gain at the expense of long-term stability [Field notes]. Nevertheless he was still willing to commit some organisational resources to the partnership.

What was striking was the degree of involvement of the voluntary sector in health partnership. In spite of the little spare resource capacity, many were entering into large partnerships and stretching organisational resources to the limit with potentially destabilising consequences. This might appear to be altruistic in the extreme.

However, as demonstrated, from a resource dependency perspective, such actions could be considered as self-interested manoeuvres either to reduce a threat to organisational resources or to maintain or increase access to additional resources. Partnership also provided an opportunity to influence the direction of service policy or development to their preference. The dominance of a systems-based view of health and partnership in the voluntary sector, as noted in Chapter 4, appeared to make it more tolerant of the immediate, potentially destabilising costs of involvement. Organisations with a larger, perhaps more secure resource base and more developed dependency relationships with the HA and SS (i.e. less asymmetric relations, as they were providing services and had negotiated a Compact showing a degree of statutory agency dependency) were better able to negotiate resources from the statutory sector to ameliorate the resource costs of engaging in the partnership process. Voluntary sector organisations or groups with the weakest resource base and capacity were the least involved, although nevertheless were striving to increase their involvement. Thus, some voluntary agencies appeared to have

transformed their position of asymmetrical dependency to one of greater mutual dependence.

Other small resource-based organisations in a similar, resource-unstable and scarce environment to the voluntary sector (i.e. PCGs, CHCs) appeared to be behaving in a similar manner. These are discussed in the next two sections.

5.3.2 PCGs

There was generally low to moderate involvement of PCGs in the HImP/HAZ partnerships at the strategic or operational levels of partnership during the first year. By the second and third years PCGs had become increasingly involved in HImPs at a strategic level. However, although some PCGs were on the HImP Steering Groups, no PCGs were in a position to chair HImP programme groups. Nevertheless, PCGs were pushing to increase their representation on health partnerships. This pattern was observed across sites, albeit with some variation, depending on the perspective of key individuals of the PCG.

National policy was influential on PCGs' involvement in health partnership. Indeed, PCGs were created as a direct result of the national policy agenda. However, this meant they had to respond to partnership while also developing organisationally. There was a duty on them to participate in HImPs and yet the notion of PCGs was barely in the public domain when local partners applied for HAZ status – thus, they were not involved in the process.

Guidance on organisational size and funding levels for management and administration costs, received from HAs, were set nationally for each level of PCG. PCGs, therefore, had a high horizontal dependency on HAs for financial resources, which were themselves operating in a resource-scarce environment. Given that there were 4-7 PCGs for each study site (rural sites tended to have more), the human resource base for each PCG was small compared to the HAs from which they were hewn. Thus, national policy set up an asymmetric resource dependency relationship with HAs in which PCGs,

particularly those at level one and two status (as was the case in the study sites), had a small resource base. Furthermore, the creation of PCGs set up a new resource dependency relationship with HAs which, by default, reduced or threatened HAs' resource base.

From their inception, PCGs were under similar pressures to other statutory organisations in the NHS – to deliver the national agenda/priorities to tight deadlines while simultaneously being required to develop lateral links with health partnerships. However, PCGs were also developing organisationally in contrast to some large statutory organisations. Thus, PCGs faced a lot of competing pressures on their organisational resources. With their small resource base, PCGs had insufficient resources to meet all these demands. The size and structure of HImP and HAZ partnerships, in part a result of government policy and guidance, made it practically impossible to place staff on all HImP groups, particularly in rural areas where the number of organisations involved in partnership was greater and the proportional share of HA resources for PCGs less.

How did PCGs respond in this context? Unlike large statutory agencies, PCGs, on the whole, did not appear to try and limit the costs of participating in partnership. On the contrary, like the voluntary sector, PCGs sought to actually increase their involvement in health partnership structures and in three sites were pushing for greater representation on partnership groups, mainly the Boards. As one MH Trust Director noted:

“Initially every PCG Chief Executive wanted to be on it, well that would have been seven straight away.”

With limited resources, the PCGs' desire to field representatives on partnership groups could be considered as altruistic. However, from a resource dependency perspective, the motives for such destabilising action would be considered self-interested, with increased representation bringing potentially increased access to resources and greater autonomy.

The data from interviewees from all sites tended to support the latter perspective. PCGs were very much fledgling organisations, still trying to find their role and establish their organisations.

In the first year of HImPs, PCGs were very internally focused and did not have the organisational capacity to get involved in partnerships. As one HImP Co-ordinator commented:

“[Q]uite a few of the PCGs have only got one staff and a dog.”

However, as their resource base grew, PCGs sought to increase their influence by extending their representation on HImPs and HAZ partnerships. In general, PCGs perceived HAs as having released very few resources for them to fulfil their statutory functions, including health improvement. PCGs were ‘crying out for every spare penny’ that they could get, pressurising the HA for more. But as noted already, the HAs were working to a ‘tight cost envelope’ and claimed not to have any spare cash.

Indeed, some PCGs were suspicious that the HA was actively tying up resources with SS and not giving them to the PCGs – for example, in Greenshire, with the creation of a joint planning unit. For its part, the HA appeared to be resisting loss of control and autonomy over resources to PCGs.

“[T]he health authority’s still retaining quite a lot of responsibility for certain things, [it] hasn’t completely devolved to the PCGs.” Director, Probation

This was despite DoH guidance (DoH 1999f) which indicated that HAs should support further delegation of financial responsibilities and commissioning to PCGs and agree with each the distribution of management resources to meet commitments in the HImP and SaFF.

Local context

However, within sites the degree of PCG involvement in HImP and HAZ partnerships also varied, depending on the local context.

Nationally, the publication of the NHS Plan (DoH 2000a) signalled that all PCGs were to become PCTs by April 2004. This indicated further organisational change at a pace greater than anticipated. PCGs were forced to consider their status in a new world of PCTs. In rural sites with a larger number of PCGs, some smaller organisations had to face the possibility of merger with larger PCGs in preparation for PCT status. Thus, the autonomy and resources of some PCGs came under direct threat. Indeed, it became a question of survival.

The threat of reducing the number of PCGs locally and the insecurity surrounding such changes in organisational boundaries, led some PCG CEOs to push their own organisational interests first. This created a climate where organisations did not wish to co-operate. Some actors became more inward-looking and competitive in attitude, acting out their own personal agendas with the HA. As one MH Trust Director noted

“For survival of your mortgage, you start doing the dirty on other people or not sharing, or holding onto [things].”

Key individuals such as PCG CEOs were reported to lack the leadership, confidence and management experience to rise above such uncertainty. Thus, these PCGs were distracted from the partnership agenda.

“People have got their eyes on the ball of who’s going to be in what PCT, who’s going to align with who and it’s major local politics going on, and I just think that until they’ve got the PCGs reconfigured and they’ve got the boundaries, people are too busy worrying about that and all the organisational change and applying for jobs and stuff to really focus on the real health improvement.” Head, HP

At a local level, the large number of organisational boundaries, particularly in rural areas, increased the likelihood that the strategic agenda would not address local issues,

thereby discouraging some PCGs, like DCs, from getting involved in HImP partnerships.

To sum up, PCGs were trying to establish themselves in a rapidly changing environment in which some organisations had an uncertain future. They sought to increase their representation on health partnerships and influence over policy after being unable to get involved in the first year, despite lack of resource and organisation capacity. At the same time, they sought to increase their share of financial resources, but this was resisted by HAs, which seemed to be protecting their autonomy. Some PCGs threatened by merger appeared to withdraw from partnership, focusing on protecting their organisations' survival.

5.3.3 Other small resource-based statutory and non-statutory organisations

A gamut of other small resource-based organisations were involved in HImP and HAZ partnership. These included CHCs, Race Equality Councils (RECs) and others. Some of these organisations had been involved in the previous joint planning structures and HFA partnerships. They were moderately involved at the strategic level in HImP partnerships (less so in HAZ partnerships) but were less involved at the programme group level.

They faced similar resource constraints to the voluntary sector although their funding base was more stable.

CHCs, like other small resource-based organisations, did not have enough organisational capacity to put representatives onto as many of the HImP groups as they would have liked.

The large size of partnerships and the short timescale imposed by central government made it difficult to find sufficient representatives. Furthermore, CHCs were also asked to attend meetings about PCGs, stretching resources further. It was a 'huge amount' for which there were no extra resources.

Nevertheless, CHCs were generally keen to be involved in the HImP and to influence health strategy, even though the work was beyond their remit of monitoring health services. Although CHC CEOs tended to express a wider, systems view of health, involvement in HImPs was left to the interests of members. As a result, local CHCs were forced to co-operate with one another to ensure their sector was properly represented across the HImP.

Although engagement with the HImP or HAZ partnerships did not hold out an opportunity to increase financial resources directly (as CHC funding is centrally set and they do not commission or provide services), it did offer the opportunity to influence service development. It also offered another route to represent the public's view and increase the CHC's profile to those outside the NHS.

In sum, small resource-based organisations appeared to be involved in health partnership in order to further their resource interests, be it to maintain or increase access to new resources or to stabilise existing resources. The greater uncertainty surrounding organisational resources, the more self-interested and resource-seeking the behaviour. Where there was slightly greater stability, the presence of a broader health perspective appeared to increase an organisation's tolerance to the costs of involvement.

5.4 Asymmetric relations and control over resources

How did the HA (and LA) as large resource-based organisations behave towards these smaller resource-based organisations? RDT hypothesises that in asymmetrical relations, the larger organisations will resist interaction which threatens their interests (resources or autonomy). Indeed, they may actively seek to maintain or extend their influence over resource-dependent organisations. Crucial to influence or power in relationships is the control over critical resources (Oliver 1990; Phillips, Lawrence et al. 2000). Did relations in HImP and HAZ partnerships show signs of an asymmetrical relationship? The next section explores the influence of the voluntary and other small, resource-based

organisations on the larger statutory organisations, in particular over their policy and resources, both of which have the potential to undermine organisational interests.

As noted already, the statutory sector was not only mandated to work in partnership but also under direction to involve the voluntary sector and other organisations with an interest in health. Small resource-based organisations were also pushing to increase their access to resources. But what was the nature of relations between small and large resource based organisations? Was the voluntary sector able to exert influence over HA and LA resources such as policy and finance? And if so, was this influence due to the asymmetry of resource bases? The next section addresses these questions, using primarily the voluntary sector as the example.

5.4.1 Increased influence of the voluntary sector?

Interviewees from all sites and sectors noted that voluntary sector involvement in health partnerships (both HImP and HAZ) did bring perceived access to, and increased influence over the health agenda in HImP and HAZ partnerships (Sullivan, Judge et al. 2004). However, this influence was perceived to be only slightly more than the sector's influence under previous partnership arrangements. Influence was strongest in the care groups established under the joint planning systems which had opened up membership to the voluntary sector.

Small resource-based organisations reported that their input into HImP strategies, for example, was fairly minimal, particularly in the first year. This was in part a result of the tight central timetable imposed on sites. Although many groups were consulted on the draft first round HImP strategy they were unable to influence its overall direction because they had not been involved in its development from the beginning. This was true even for voluntary sector organisations involved in existing JPGs.

Although interviewees reported their engagement in the process improved in the second and third years of the HImP, there were still reservations about the degree of involvement and influence over health policy.

Influence over policy – voluntary sector trying to influence policy and allocation

Many in the voluntary sector felt that statutory agencies assumed a top-down approach to involving the voluntary sector without a commitment to including them in decision-making. They complained that they were ‘not listened to’ or their views were ‘ignored’.

The general lack of influence over policy in health partnership – although some interviewees claimed that it was too early to tell – undermined relationships between the two sectors. Consequently, the voluntary sector in general felt a degree of distrust and marginalisation, and perceived that statutory sector engagement with this sector was insincere and ‘tokenistic’. Indeed, some suspected the statutory sector only wanted to involve them because government guidance stipulated their inclusion.

“There is a bit of a sense of consultation sometimes happening because there’s an obligation to consult, but the decisions have already been made.”
Director, VS

The statutory sector, for its part, recognised that the voluntary sector felt excluded, lacked sufficient voice and was not equal in influence. However, no sites were seeking to remedy this through developing a strategic approach to involvement. Even where the voluntary sector was reported to have had more impact, the statutory sector still recognised that there were limits to voluntary sector influence. Giving the voluntary sector a voice did not mean ‘anything goes’. Their wishes were tempered by organisational and managerial constraints on the statutory sector.

“[The voluntary sector would] come to meetings, they’d said what they thought older people needed, what they thought the main priorities were, and in all instances that wasn’t necessarily reflected in the final document. And I think this is an issue of, in part, an unrealistic expectation on behalf of people in terms of the extent to which their contribution really could be actually reflected in the final document.” HImP Co-ordinator

5.4.2 Influence over resources

RDT argues that in asymmetrical relations, organisations seek to influence resource exchange in their own interests. For the voluntary sector this would not only mean securing access to finance but also influencing policy and service development towards their perspective.

However, of the few organisations which reported having an influence over policy, even fewer reported that their influence extended to resource allocation. This was because resources were allocated in the SaFF, JIP or remaining Joint Planning Groups (JPGs), all of which were at the margins of the HImP partnership structures.

The lack of a budget in HImP partnerships, coupled with the structure, served to undermine the voluntary sector influence over resources, whether it was allocation of joint finance or mainstream statutory budgets. This frustrated some in the voluntary sector who saw themselves as being excluded from ‘the real meeting’ where resource decisions about core funding were taken. Some in the voluntary sector only started to become aware of this over time.

“When does the voluntary sector get invited to those SaFF meetings, to argue for the mainstreaming of their funding? [...] what do you mean mainstreaming? [...] the definition of the mainstream *is* were you at the SaFF meeting? No. Well you’re not bloody mainstream.” Director, VS

Thus, the voluntary sector was in effect participating in *tokenism* (Arnstein 1969) or *non-decision making* (Bachrach and Baratz 1963), as senior staff within the HA and SS were dealing with resource issues outside the HImP structure and agenda. This *de facto* exclusion by statutory agencies of the voluntary sector from forums where decisions on mainstream resources were being made in effect amounted to an exercise of the *second dimension* of power (Bachrach and Baratz 1962; Lukes 1974).

A few voluntary sector groups did report some influence over resource allocation, through being involved in writing local strategy (i.e. on older people and carers) or

commissioning, mainly through involvement in established JPGs. In general, however, there was weak involvement of the voluntary sector in joint commissioning/planning groups and therefore little influence over resource allocation. Indeed, in one site voluntary sector groups that had received funding from the HA and SS were deliberately excluded because they were deemed to have ‘vested interests’, although this argument was not applied to SS who were also purchasers and providers. Again, the voluntary sector appeared to be deliberately kept away from the real action.

Indeed, other actors in small resource-based organisations argued that the new partnership arrangement had reduced their direct influence over resources, particularly with the demise of the Joint Care Planning Teams which had JF monies to allocate. Influence was now more indirect, through development of strategy on the HImP.

In HAZ partnerships – where there was some direct control over resources – the voluntary sector appeared to have slightly greater influence over the direction of resources. However, it was generally suspicious of the motives of the statutory sector which it perceived as trying to direct resources back into its own sector or towards its own priorities (into existing services or on government priorities such as winter pressures) rather than those espoused by the voluntary sector. Indeed, in Metrocity, the voluntary sector challenged the HAZ Board for spending too much of the funds on the statutory agencies and not enough on their sector [Field notes], although this was refuted by the HAZ Co-ordinator.

This created a competitive tension between sectors for resources. The reaction of the voluntary sector to its lack of ‘power’ over policy and resources was to push for greater representation on, and links with partnership groups or to take a more aggressive stance when pushing its view.

Voluntary sector manoeuvring

Where the voluntary sector’s advocacy was strong or forthright it tended to make the statutory sector defensive. The voluntary sector frequently criticised the statutory agencies for their reliance on the medical model, but some in the statutory sector

claimed that the voluntary sector's assumptions were unfounded. Indeed, it was argued by some statutory sector interviewees that the social model promoted by the voluntary sector also contained elements of the medical model, such as patronage.

Paradoxically, the overt expression of sectional interests by the voluntary sector in an effort to influence the agenda appeared to block or hinder the sector's influence, turning other people off. But the voluntary sector often felt disposed to push its position because of its perceived lack of power or influence.

“[S]omebody once referred to [our representative] as being a bit like a Rottweiler, but she has to be because she has to defend the position of the voluntary sector. She has to keep on letting them know that the voluntary sector is there.” Director, VS

This could impact on group dynamics and lead to poor attendance or withdrawal of individuals or partners from the group or impasse.

Why did the voluntary sector appear to wield so little influence in health partnership over policy and resources? This is considered next.

Influences over policy and resource allocation

The resources that partner organisations could command or bring to the partnership table appeared to be a significant factor in reflecting the degree of influence an organisation could bring to bear on the partnership agenda and allocation of resources. In general, unequal inputs appeared to result in unequal influence, even when the interactional dynamics were such that all partners had an ‘equal voice’. Although the voluntary sector was, in general, welcomed into the health partnerships, their low resource base meant their voice was less likely to be ‘heard’ or taken into account. As one VS Director put it:

“It’s hard to feel equal as partners because we don’t have any money really do we, so you sometimes feel that other partners have all [...] the weapons

if you like, because they can make partnership easier for you by the way they fund you, or more difficult because of how they don't fund you."

In partnerships where the voluntary sector contributed more substantial resources their influence was greater and could even surpass that of some statutory agencies, especially when the sector was allowed an equal voice through less partisan chairing. As another VS Director noted when contrasting voluntary sector influence in the HAZ to that in an SRB partnership, where the voluntary sector was contributing £2 million towards the partnership's work and the health authority only £200,000:

"[I]t's much more balanced then in terms of the kind of debate and who takes part in it. But then we've got quite a different stake in something like that [...] so the dynamics are different round the Board."

The national agenda served to reduce the degree of influence of the voluntary sector on the local agenda in a number of ways, as noted in Chapter 3. Although national priorities provided an opportunity for some voluntary sector organisations to get involved and promote their agenda, in practice the policy frameworks pushed down from the centre were rigid and directive. Thus, the NSF for MH restricted and weakened the contribution from voluntary organisations. The focus on a small number of national priorities also marginalized voluntary sector organisations not working on these priorities i.e. physical disability organisations. Meanwhile the large policy agenda and tight central timetables for implementation 'froze out' the voluntary sector because it did not have the capacity to respond. The pace of the agenda and the short timetable did not allow robust relations to form, but on the contrary, made the voluntary sector feel disempowered and marginalized. Statutory agencies' heavy dependency on government resources created a strong incentive to comply with the centre's demands to implement its large and changing policy agenda. The result was HImP strategies written very much from a statutory agency point of view. This led many in the sector to question whether the statutory agencies were serious about allowing it to contribute to local decision-making, resulting in cynicism and distrust.

In sum, despite their lack of organisational resources to fully participate in HImP and HAZ partnerships, small resource-based organisations were eager to stretch their capacity to a maximum, almost to the point of jeopardising their financial well-being. The motivation for such behaviour appeared to be to maintain or secure resources from organisations on which they were dependent. Organisational turbulence and a resource-scarce environment seemed to add to their concern about their resource base. Entering into partnership was also perceived to provide an opportunity for these organisations to extend their interests and influence over the policy and service development of the large resource-based organisations on which they were generally dependent. This was particularly the case for voluntary sector organisations whose involvement in partnership was voluntary. It also appeared to be reflected in the behaviour of other small-resource-based organisations, even those which had a duty to participate (PCGs). However, while the large resource-based organisations appeared keen to involve these small resource-based organisations, influence over policy was limited and rarely led to the allocation of resources, except for HAZ monies. Indeed, these organisations reported their influence over resources as having diminished in the new partnership arrangements. There was also a general perception that the agenda and resources were set by the large resource-based organisations and reflected the government's agenda.

5.5 Conclusion

This chapter has explored the dynamics of horizontal relations between organisations and individuals in case study sites. It used RDT as a framework to explain the degree of involvement and the nature of engagement between individuals, organisations and different sectors.

Part I of this chapter considered the degree of involvement of organisations with a large, fairly symmetrical resource base, such as the HA, LA departments and NHS trusts in health partnership. It showed how the factors identified in Figure 4.1 in Chapter 4 as influencing costs and benefits combined to produce general patterns of involvement. It also showed how variations in involvement within sites (Community Services) and between sites (Dalesville and Greenshire) could also be accounted using Figure 4.1. The cost-benefit calculations of large resource-based organisations appeared to differ from

those of small resource-based organisations. For the large organisations, where there was a mandate or duty to participate in health partnerships (i.e. HImPs), the degree of involvement appeared to depend on a cost-benefit calculation of the process. Actors who perceived the process costs as high with respect to the benefits were less likely to be involved. The presence of additional resources in voluntary partnerships (i.e. HAZs), especially in a resource-scarce environment, could swing the balance, even for actors who had a very narrow perspective of health and were more sensitive to the costs (i.e. Trusts). However, engagement with the other partners over core resource allocation in general appeared to be unchanged. In HImPs, this was largely due to the fact that partnerships had no resources or direct accountability for budgets. Although organisations had re-negotiated work boundaries in the areas of commissioning and provision for some care groups in some study sites, resulting in greater transparency over resources (financial and informational), large resource-based organisations still had not relinquished control over core budgets. The degree of symmetry between these large resource-based organisations appeared to limit the extent of influence or coercion one organisation could exert over another. Large resource-based organisations, therefore, appeared happy to engage and negotiate areas of joint work or ‘zones of legitimacy’ as long as they did not directly threaten their control or autonomy over core financial resources. Where the balance in dependency relations was disturbed, a hiatus in relations developed.

Part 11 examined the levels of engagement of organisations with a small resource base and asymmetrical resource dependency, such as voluntary organisations, PCGs and other small statutory (CHCs) organisations. In contrast to the large resource-based organisations, involvement of small resource-based organisations in health partnership appeared to be more driven by the presence of a weak and unstable resource base and asymmetrical resource dependencies. Although conscious of the costs associated with the process of partnership, small resource-based organisations seemed more willing to stretch themselves in order to maintain or increase their resources or promote their interests. However, their weak resource base and their dependency on larger resource-based organisations such as HAs and LAs for resources appeared to undermine their ability to exert influence over the health agenda and resource allocation. The large resource-based organisations, although willing to involve smaller resource-based

organisations in health partnerships, were reluctant to lose control over core resources – in other words their power. However, where resources were less critical, such as additional HAZ funds, the voluntary sector was able to exert some influence. Generally, the large resource-based organisations were only willing to adjust their position under pressure from their asymmetrical vertical dependency relationship – the government. This was felt by many, particularly in the voluntary sector, who either became disillusioned with the process or, in response to the perceived lack of influence, tried to push their view more forcefully, antagonising other partners. Asymmetry of resource dependency relations and the size of resource base appeared to be important to the degree and nature of involvement of organisations in health partnership. Overall, although involvement of the voluntary sector in health partnership increased, its influence over resources and policy, outside HAZ partnerships, arguably decreased. With control over resources residing firmly with the large statutory organisations, partnership as *participation* did not appear to have been achieved.

While RDT provided a relatively powerful framework to describe the factors that influenced involvement in partnership and the nature of relations, its determinism did not address the role of individual actors in managing the process and outcome of partnership. The next chapter uses Collaboration Theory to gain greater insight into this aspect of partnership.

Chapter 6 – Partnership process, joined-up opportunism and joined-up thinking

6.1 Introduction

This chapter explores the nature of processes and outcomes of HImP and HAZ partnerships. It draws on Collaboration Theory to provide a third framework with which to examine relationships between partners and explain how these relate to different types of partnership outcome. It seeks to address my third research question: what was the nature of the process in partnership and how did this relate to the outcomes of partnership? In so doing, it contributes to an assessment of whether HImP and HAZ partnerships were partnership as *collaboration* or partnership as *co-ordination*.

Collaboration Theory (CT) primarily focuses on the structuring and management of interaction or *process* in partnership in order to come up with new approaches to complex social problems. HImP and HAZ partnerships were very much framed in these terms – a way of providing innovative solutions to tackle poor health and widening inequalities. As argued in Chapter 1 in the section on Theoretical Frameworks, CT was an appropriate theory with which to explore the processes and outcomes of partnership.

CT focuses on the structuring of interaction in partnership. This is achieved through a process of ‘managed’ negotiation in which partners recognise that the problem is mutual and can be resolved collectively. There are two elements to structuring negotiation: *cognitive* and *social* (Schuman 1996). Managing cognitive negotiation involves problem-solving and consensus-building. Problem-solving requires ‘reframing’: participants share appraisals and perceptions of the problem and through negotiation arrive at a new *joint appreciation* (Trist 1983). Innovation or radical synergy emerges from this conflictual process, in which participants’ views and assumptions are challenged, and differences resolved through negotiation (Kickert, Klijn et al. 1997b; Hoggett 2003). Where this process is absent (information is just exchanged), the

existing normative order will only be marginally improved, and co-ordination or incremental synergy will be the outcome (Roberts and Bradley 1991).

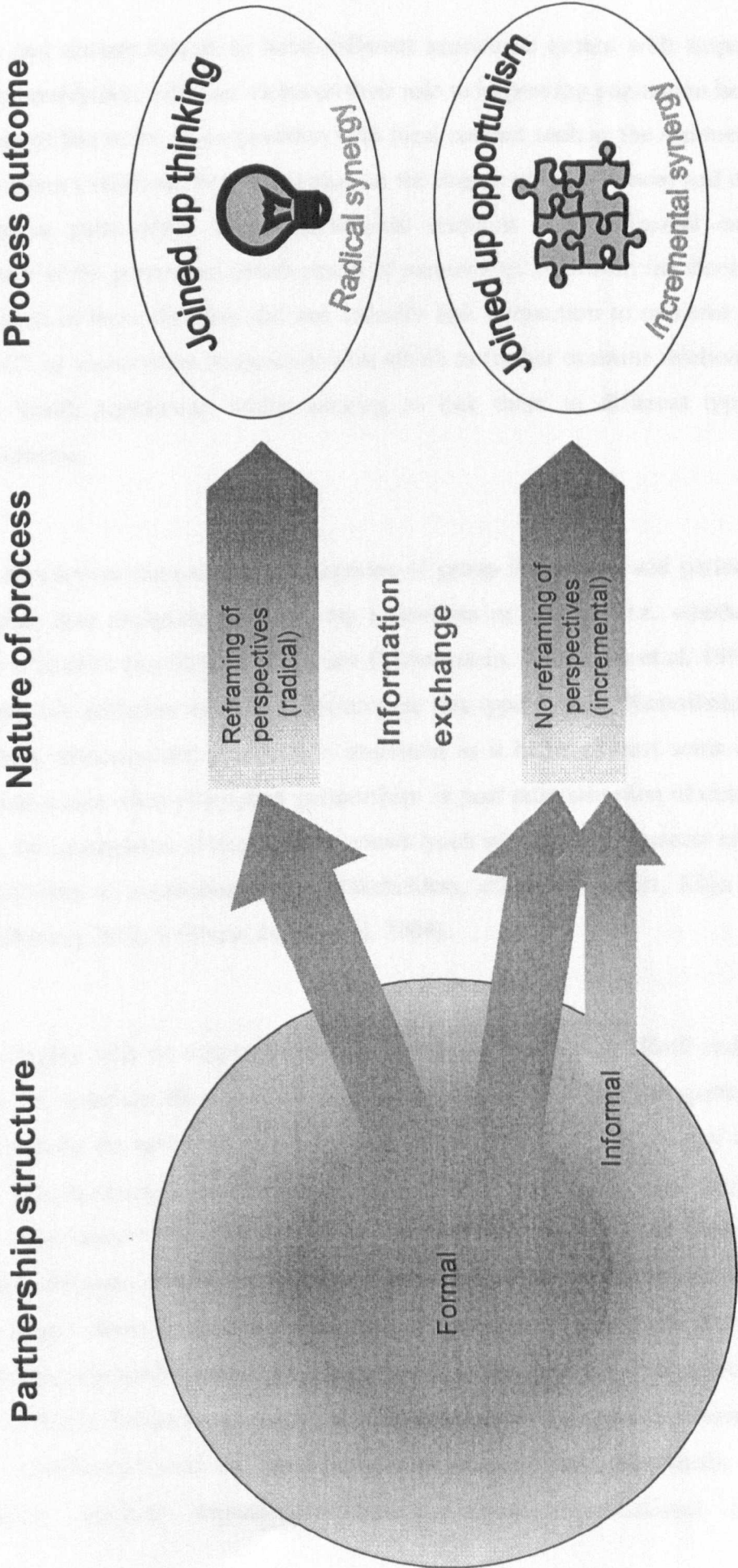
Figure 6.1 illustrates the different processual routes to radical and incremental synergy. However, achieving a new ‘negotiated order’ requires a re-negotiation of the existing ‘social order’. As group members have established ways of working, patterns of interaction and interdependencies and interests, this requires careful management or social structuring; otherwise tensions between powerful and less powerful actors may undermine the process (Eden and Ackerman 2001) and solutions may be imposed or vetoed.

The key to achieving managed negotiation is a just process. This means communicative interaction i.e. dialogue, discussion and debate, must be constructive, fair, inclusive, transparent and equal (Kickert, Klijn et al. 1997b; Taket and White 2000b; Eden and Ackerman 2001). The use of external facilitators, with expertise in collaborative management but with no authority or vested interest in the outcome, can be an effective way to improve performance (Huxham 1996; Rosenhead and Mingers 2001b).

CT assumes actors are willing to engage in partnership, are able to ‘reframe’ and that conflict is positive and if managed constructively can lead to creative outcomes. Yet paradoxically, the differences which enable a group to ‘think’ in new ways – different views, perspectives, skills and interests – make it more difficult to negotiate a new consensus (Lichtenstein, Alexander et al. 1997; Phillips, Lawrence et al. 2000; Turcotte and Pasquero 2001). Large, diverse groups, together with changing membership and ambiguous and complex structures, can undermine the interactive process, creating inertia (Huxham and Vangen 2000a).

Chapter 3 showed how central government command and control mechanisms influenced the nature of interaction, the process of partnership development and quality of outcome. Chapters 4 and 5 showed how actors from different departments,

Figure 6.1. The process of generating joined-up thinking and opportunism in partnership



organisations and sectors tended to have different normative orders with respect to health and partnership (i.e. different views on their role in improving population health). The orientation of this order, in conjunction with local context such as the symmetry of resource dependency relations, was influential on the degree of involvement and nature of interaction in partnership. Thus, hierarchical relations and horizontal context appeared to restrict the processual development of partnership. However, the theoretical frameworks used in these chapters did not casually link interaction to outcome. This chapter uses CT as a normative framework with which to further examine relations and processes in health partnership whilst seeking to link them to different types of partnership outcome.

The chapter focuses on respondents' perceptions of group interaction and partnership outcomes rather than analysing actual group interaction or outcome i.e. whether the outcome had a positive (health) impact or not (Lichtenstein, Alexander et al. 1997), as resources were not sufficient to collect and analyse this type of data. Nevertheless, an analysis of how outcomes are produced is important as it helps address some of the methodological issues when evaluating partnership: *ex post* rationalisation of outcomes (attribution), the aggregation of respondents' views (each with different success criteria) and the boundaries of evaluation (time, stakeholders, effects) (Kickert, Klijn et al. 1997b; Glendinning 2002; Sullivan, Judge et al. 2004).

The chapter begins with an exploration of the nature of relations in HImP and HAZ partnerships. It examines the level of communication in and between partnership groups. It questions the nature of discussion and debate. Was it open and equal in case study sites? Was there any reported evidence of conflict or consensus? If so, where and how did it come about? The chapter shows that although there was an increase in communication between partners in formal and informal settings, and a degree of open, two-way dialogue between agencies, developing a negotiated consensus through a process of debate appeared to be *ad hoc* and sporadic. Decision-making was impeded by partnership structure, hierarchical constraints (large and directive agenda, timescale and lack of a co-ordinator) and by local horizontal context (key individuals, group size/boundaries, resource dependencies/financial issues, organisational culture/

professional views outlined above). Thus, a fundamental process of collaboration appeared not to have been achieved.

The chapter then focuses on the evidence for *joint appreciation* or radical innovation i.e. a shift in conceptual understanding of the problem. It identifies examples of new initiatives arising from partnership, and where and how they occurred. It questions whether incremental or radical synergy was evident. Examples of radical synergy or 'joined-up thinking' seemed few and far between. Where joined-up thinking was identified, it tended to occur in well-established HImP sub-groups where there was increased membership and a willingness to be open to new views, or where access to new information or scope of work had increased. However, incremental synergy or 'joined-up opportunism' was more in evidence, and occurred as a result of increased links and networking between actors within and outside the formal partnership structures, as illustrated in Figure 6.1. Finally, it concludes that partnership as *co-ordination* was the predominant feature of health partnership, rather than the ideal of partnership as *collaboration*.

6.2 Communication in partnership

Communication is central to Collaboration Theory. Empirical evidence suggests that it is an important enabler or block to successful collaboration or partnership (Fasel 2000), as noted in Chapter 1. Joint appreciation requires a two-way communication between partners where they are encouraged to exchange information and modify their perspectives and interests through negotiation.

Communication refers to the channels used by partners to send and receive information, keep one another informed, and convey opinions to influence the group's actions (Mattessich and Monsey 1992). It can take place in many forms and places. While much communication is verbal and face-to-face, these are not the only mechanisms: visual and textual media such as pictures, documents, letters, telephone and e-mail may also be used (McKenny, Zack et al. 1992; Nohria and Eccles 1992b). Communication can take place within the formal environment of a partnership meeting (hereafter termed formal

communication) or in a more informal setting (Mattessich and Monsey 1992) i.e. over the telephone or a chance meeting while at a partner organisation (informal communication). It is through this process of interaction that participants reveal to one another and interpret their roles and identities, their intentions and the meaning of their actions (Nohria and Eccles 1992b).

This section is concerned with the level and quality of communication in health partnerships rather than the effectiveness of the media or mechanism used. What was the nature of communication and how did this relate to the nature of interaction and process outcomes in case study sites? Communication of partners' views and of their resource needs should be open and honest, with equality in the process of discussion, negotiation and decision-making (Kickert, Klijn et al. 1997b). Was this achieved in health partnerships? This is discussed next.

6.2.1 Increased communication

Communication was widely reported by respondents from all sites and sectors to have increased significantly since the establishment of HImP and HAZ partnerships, although some of the increase was attributed to other concurrent initiatives i.e. ABIs. Respondents reported using a variety of media and mechanisms such as those identified above (excluding pictures). A number of interviewees remarked on the dramatic improvement in communication between partners compared to five years earlier. Improved communication was not just reported between people involved in formal HImP and HAZ partnerships but also in informal settings, with personal connections made between individuals and organisations beyond these partnership structures, many of whom would not have communicated otherwise.

“The leads of the new HImP programme groups are from outside of the health service. So they’re new coming into it, and maybe have not had that contact with us in the past.” Director, CHC

All sites reported an increase in networking or connectivity between people and organisations at different levels as well as some networking between networks, often

building on previous relations and links in sites. There was open-door communication, with individuals from all sectors reporting that they could informally approach their opposite number in a partner organisation.

“[I] can ring up any member on the partnership and say that we need to talk or sort this out or there are these issues. So there’s that informal level of working relationship as well.” Director, VS

Some interviewees reported a number of ‘cold contacts’ from LA departments where there was no previous relationship.

6.2.2 Communicating in the same language?

An important issue central to communication and frequently identified in the empirical literature is language. Verbal communication can be hindered by use of different professional or technical terms and acronyms – what Nash calls the jargon of professions (Nash 1993). The use of different language or jargon, whether in meetings or documents/papers, can cloud or obfuscate understanding as different words or terms are used to describe the same issue or problem, or the same word can convey different meanings to different professional groups. Use of jargon can cause poor communication and undermine participation by not allowing partners to communicate meaningfully with one another. Jargon can inhibit, for example, the flow and interchange of different perspectives and ideas, undermining partnership synergy (Termeer and Koppenjan 1997; Lasker, Weiss et al. 2001). Those not familiar with a certain professional language may be inadvertently (or deliberately) excluded from discussions during meetings. As one Director of SS noted:

“[I]t is hellishly confusing, the language is used and misused pretty wilfully, and for the people who are on the outside of it, it’s still incredibly hard to understand and conceive of.”

The use of different languages by different sectors or organisations when describing the health or social world was mentioned by nearly a quarter of coded interviewees based in

all sites (13/60). Differences in language used in HAs and LAs (SS and other departments) were identified as problematic. However, some respondents noted that for organisations that had been working together for years, such as statutory organisations, language was less of an issue. For the voluntary sector, however, health jargon could still be a problem, with poor comprehension limiting an actor's ability to participate. In HAZ partnerships, it had contributed to a lack of clarity and confusion about funding streams, criteria and deadlines for money, not helped by the shifting demands of central government, as noted in Chapter 3.

Although different languages presented a 'challenge' to partnership, it was far from an insurmountable barrier – jargon could be 'learned quickly'. Three sites mentioned conscious efforts to improve the language barrier, through 'reader panels' to de-jargonise pre-consultation documents or by giving examples of how partnerships' medical priorities might link with the LA agenda.

There was also some work on improving information-sharing between organisations in most sites through, for example, improved IT links. In Greenshire, where this work was the most advanced, the HA was working to improve access to NHS Net as well as to develop a joint database between the HA and SS.

There were also conscious efforts at improving communication between partners by the partnerships themselves. These included newsletters, specific presentations, educational seminars and information days (in some sites held monthly), on specific policy areas. These were organised at different levels within the partnership structure but notably amongst the higher steering group levels. Most sites had partnership days to review work (in two sites using external facilitators), special fora to address specific issues or presentations within meetings.

An increase in formal and informal communication in all sites led to an increase in intra and inter-organisational awareness amongst partners in HImP or HAZ partnerships, and of health as a local issue. For example, directors of HAs (aside from DPHs) had become

increasingly aware of what their health promotion departments were doing in relation to the health partnership agenda. Increased communication had led to greater understanding of internal structures and decision-making mechanisms, approaches to and contents of work, organisational constraints, the types of services provided and the agenda. It helped individuals appreciate what was driving people in other organisations.

“[G]etting across exactly how other organisations can contribute, not necessarily by spending more money, but changing what they do and by increasing their awareness of public health issues [...] people can see that a lot more now than they could a few years ago.” Manager, HP

Knowing whom to contact, when and where, and talking to a friendly face could make a difference when tackling ‘hard’ issues. Better communication and awareness enabled partners to be clear about each other’s roles and responsibilities (i.e. of elected members), avoiding misunderstanding. In some organisations, this had opened their eyes as to what could be done in terms of the health and partnership agenda.

Unsurprisingly, in the formal partnership structures, communication was reported to be better in groups that met more frequently or had worked together previously. Reports on the quality of communication in HImP/HAZ sub-groups was often more favourable than in steering groups which tended to meet less often (i.e. bi-monthly or quarterly).

Furthermore, although widely recognised as improved, communication was also reported to be far from ideal. Partnership had increased communication links but the number of health and other partnerships, their large size and structures also limited communication and decision-making. Communication across the large and complex HImP/HAZ partnership structures (i.e. between groups) both laterally and vertically was reported as weak and *ad hoc* in all health partnership sites. As one HImP Board member noted:

“[D]espite attempts to get better linkages, the communication needs to be improved, as to who’s doing what and who’s working with who.” CEO, LA

The influence of structure on communication is explored next.

6.2.3 Influence of partnership structure on communication

Government policy did not prescribe the structure of HImP and HAZ partnerships but allowed for a large degree of flexibility. The combination of national priorities and guidance and organisational reform coupled with local circumstance and history resulted in very different partnership structures in each study site, with different accountability and governance structures, health foci, approaches to voluntary sector involvement and links with other partnerships (see Appendix N). Indeed, these issues were the subject of debate and negotiation, which, in some sites, was quite protracted and time-consuming.

However, analysis revealed some common features. First, there was a plethora of partnership structures resulting from different government department initiatives and existing initiatives (see Chapter 1). Second, the broad nature of the issues partnerships were set up to address coupled with the large number of government priorities resulted in large health partnership structures with many sub-groups, as noted in Chapter 5. These structures were unevenly developed. Third, the requirement for partnerships to be inclusive together with the creation of new organisations (i.e. PCTs) resulted in large partnership groups, with a membership of between 15-30, especially in rural areas with multiple organisational boundaries. Group size is discussed in more detail in the section on consensus and decision-making later in the chapter.

These features led to ‘very complicated’, ‘dense’, ‘untidy’, ‘extremely convoluted’ and ‘cumbersome’ partnership structures, which were difficult to map. Many individuals reported that they did not understand the structures or how partnerships integrated or aligned with other organisational systems – for example, how the HImP and HAZ partnerships related to each other. In Dalesville, the HAZ Co-ordinator described the partnership as ‘kind of floating about somewhere not really connected to anything’, while in Metrocity, one group member described the complexity of local structures as like ‘a Russian novel’.

“I don’t even know what’s going on in this structure most of the time and that’s no criticism of individuals, it’s a big system and I don’t think enough time and resource has been put into developing the communication, structure and strategy.” Head, HP

Lack of clarity and confusion about structures hindered communications between different parts of the partnership. For example, steering group members frequently complained they were unaware of what was happening in the lower tiers of the HImP/HAZ partnerships across all sites.

As one CEO PCG noted when talking about the different tiers in the HImP partnership:

“[I] feel sufficiently distanced from the process to not understand the difference, really, between what goes on in those two groups [the HImP Board and HImP Programme Group], and thus, where I should even seek to influence.” CEO, PCG

Communications were more difficult for organisations that could not field sufficient staff for the numerous partnership groups, generally small resource-based organisations (such as the voluntary sector or PCGs). In some instances, lack of capacity created an additional link in the communications chain, as organisations were forced to rely on sectoral representatives to feed back, creating distance from what was going on.

Poor communication meant many individuals from all sectors did not fully understand the accountability and governance mechanisms.

“[I]t’s not a clear process, there are no clear lines of accountability. The bulk of the commissioning is going on over here, and then HAZ is dropping in some additional funds direct into the providers and other places, that may or may not be in line with the Joint Investment Plan for older people.” CEO, PCG

The large partnership structures were also difficult to manage. Sub-groups, for example, were reported as going off in different directions, making it difficult to maintain a coherent, collective vision within the partnership. Thus, the lack of clarity generated by complex structures led to a slower process, inertia in decision-making and a lack of action. Huxham (2000a) has also noted that ambiguity and complexity in structure can lead to ‘collaborative inertia.’

However, a handful of respondents argued that although there was ‘no perfect way’ to structure the partnership; it was inevitably complicated and messy. Health partnership, nevertheless, represented greater engagement and communication between partners than previously attained, albeit with duplication, ‘holes’ and bits that did not work.

Generally across case study sites, increased communication had led to learning about the structure of social relations, of existing networks and the interests of other participants (Turcotte and Pasquero 2001), in spite of the obstacles highlighted above.

6.2.4 Quality of interaction

Communication and interaction had improved dramatically between HAs and LAs, in particular. In several sites, this relationship was considered better than between the LA’s own departments. There was generally a willingness and positive attitude towards working in partnership, as noted in Chapter 3, unlike relations in the past that had seemed ‘tokenistic’. In partnership groups, communication was generally described by respondents as ‘two-way’, a ‘dialogue’, ‘open or honest’, and ‘sufficiently robust to discuss dislikes’, especially between statutory agencies (HA/LA/Trust). This was accompanied by a varying increase in transparency over information and resources in sites, especially between HA and Trusts but also with some SS departments. The result was a quality and depth to relations.

The exception was in Dalesville where there was still a ‘real lack of understanding’ between the HA and SS about each other’s organisational structure and culture, together

with a lack of communication or transparency over financial resources, in part related to changing resource dependency patterns (see Chapter 5) but also as a result of key individuals with forceful personalities dominating relations.

The quality of relations with the voluntary sector was reported as more mixed, with some groups reporting 'one-way' or 'opaque' communications and the persistence of patronising attitudes. This was in part related to the late involvement of the sector in developing the partnerships, strong government steer and frenetic pace in group agendas, as noted in Chapter 3, but also due to their lack of resource base and the lack of mainstream resources attached to the HImP, as explained in Chapter 5. Where communication was reported as good and two-way, the voluntary sector had negotiated (previous to the advent of the HImP) or were negotiating a Compact which set out clearly the roles and responsibilities of statutory agencies with the sector (Greenshires and Middleton).

6.2.5 The limitation of formal communication channels

Informal communication or networking was considered an important adjunct to communications in formal partnership structures, and was built on the back of stable partnership and organisational structures. The large number of partnerships and their large structures provided opportunity for informal contact between individuals and their organisations. This view was echoed by respondents in a number of partnerships in three sites. Informal communications were different to the dynamics of communication in meetings. Indeed, effective partnership was considered by some to operate at these two levels.

Communicating in formal partnership structures was important in bringing individuals or organisations together who previously had no relation. The formal structure provided the framework in which to make decisions and to take action. However, the low frequency of contact between partners in such formal fora often did not allow sufficient quality of communication to develop for decision-making. Indeed, there could be a certain dynamic to formal relations that constrained discussions or exploration of topics

(see below). The tight timetable and large agenda made for a crowded and busy agenda. Similarly, some respondents commented about talking in meetings but not being heard. This was supported by observational work, although as noted above, some partnerships did create space and time for more structured discussion with the use of facilitated away-days.

Informal communication or networking could provide a counter weight to communication in formal relationships. It could allow access to knowledge and expertise which might otherwise be overlooked. Several respondents reported that informal communication, some taking place directly after partnership meetings, for example, had led to the development of innovative project ideas (this is discussed in more detail later in the section on co-ordination). Communicating in informal situations was not only perceived as important to building relations and mutual understanding but also in taking the partnership agenda forward. Informal links helped produce a better, more informed and cohesive group (Mattessich and Monsey 1992, pp.13). However, communicating through informal relations was not sufficient on its own. Formal structures and therefore formal communications were required not only to provide management and structure for decision-making but also accountability mechanisms.

Thus, the level and quality of communications between agencies and organisations in partnership was reported to have increased with the introduction of health partnerships, especially between statutory agencies (HAs/LAs/Trusts) but less so with the voluntary sector. Communication was generally described as two-way (dialogue), open and honest, although the voluntary sector felt that communication was more mixed and at times unequal. Communication in groups developed from previous partnership arrangements appeared to be strongest. On the other hand communication *between* partnership groups was generally described as relatively poor and *ad hoc*, partly due to the complex structural arrangements, the large number of groups and their uneven development, making processes opaque.

CT identifies dialogue, discussion and negotiation as inherent features of the process of reaching a shared appreciation or consensus. This is essentially a self-conscious process

which may need facilitating or steering to achieve. Was this understanding held by respondents? Were they aware of this process and was there any evidence of this process having been followed? The next section explores the normative views of respondents in relation to communicative interaction in partnership process. These are then contrasted with the reported experiences of working in partnership.

6.3 Communicative interaction in the process of partnership – a normative view

Many respondents assumed or talked, explicitly or implicitly, about the need to explore different partners' points of view in order to find common ground or consensus. Some expressed a view that it was better to compromise their position than jeopardise relations. This process required people to be listened to, to be open and flexible – 'constructive talking' or 'hard argument' – so that issues or decisions 'were questioned' or 'thrashed out'. It required a good chair to ensure all partners had an opportunity to express their views in a relaxed atmosphere, have a willingness to learn and understand ('open-minded'), show respect and accept difference. Debating an issue was part of the creative process, the way 'joined-up thinking' was achieved rather than 'joined-up opportunism' (this is explored in more detail later). It led to innovation rather than just *ad-hoc* improvement of co-ordination between policies and programmes. The ability to 'handle' disagreement was considered a test of partnership, an expression of its robustness in the face of tension. This normative understanding of partnership was espoused by many interviewees and reflected an idealised, systems-based view of partnership, closely resembling that presented in Collaboration Theory. How did this normative view compare to the reality of health partnership? Was there discussion and debate and, if so, in which sites, and where in the partnership structures? This is explored next.

6.3.1 *Achieving consensus? Mixed views on the partnership process*

The reported reality of communicative interrelations in partnership was far from this ideal. Discussions in HImPs groups and between agencies were described by many as 'frank', 'fairly lively', 'engaging', 'genuine' and 'on-going'. Debate and discussions were reported on many issues, including the structure of the HImP or partnership (i.e.

HC), the legitimacy of partners, changes in service provision or domain (Coronary Artery Bypass Graft (CABG), health visitors, community care) or direction of new services (health promotion) in HAZ, financial issues and over evidence (asthma). While many respondents reported that there were no major disagreements between partners, closer analysis of the data identified a range of contentious issues which were not evenly distributed between sites but showed some common threads. Financial resources were where there was the largest disagreement, whether over the allocation and distribution of additional sums or changes to underlying resource dependencies. Issues identified related to how much was to be allocated, who should receive it, the fairness of the process, whether some partners were getting more than their fair share, funding, or concerns about off-loading costs. These were discussed in Chapters 4 and 5. In two sites in particular – Dalesville and Metrocity (to a lesser degree) – this led to a complex picture when trying to achieve consensus between partners in HImP, HAZ and other local partnerships. Here, consensus was not always forth-coming or even illusory. It was achieved by keeping more substantive or controversial issues (i.e. resource issues and dependencies) off the agenda. In some cases, decisions at the board level were considered a formality as no real alternatives were presented. These two sites are considered briefly below.

Dalesville - consensus or non decision-making?

In Dalesville, consensus appeared to be illusory for two reasons. Firstly, despite nearly all respondents reporting that relations in the HAZ and the late-developing HImP partnership were courteous, calm and not contentious, many respondents also noted that there was actually no culture of debate in local partnerships. The apparent harmonious relations, however, did not mean consensus had been attained or shared appreciation reached. On the contrary, local partnerships had developed, over the years, an etiquette of acceptable or polite behaviour. It was a culture in which there was deference to the HA in health partnerships and to the LA in regeneration partnerships, leaving issues and decision-making uncontested or unquestioned. It was in part the result of the nature of relations between the two key individuals, the HA and LA CEOs and the structure of partnership financing, with accountability and allocations directed through the respective agencies. This arrangement conveniently allowed both key players to make decisions without proper consultation or discussion. This culture had been quickly

replicated in the HAZ, and to a lesser degree the HImP. In the HAZ, it was assisted by the lack of a decision-making framework for the first ten months which allowed the HAZ Chair, the HA CEO, to veto or impose decisions without consultation. As a voluntary sector director who felt excluded by such behaviour put it:

“The meetings themselves are just very, terribly well mannered, so you don't get any blood on the carpet, which is probably part of the problem. You know, they will want to sort it out privately somewhere, and agree on what the approach will be.”

Secondly, difficult issues were kept out of the partnership forums (HImP) to be settled in private, bi-lateral fora by the organisations concerned. In this way the larger, perhaps more radical agenda was avoided and partnership tended to focus on small, less controversial issues. A key issue in this respect was related to the criteria for care in the community between the HA and SS. Settling these issues had major financial implications for both institutions. It also had potential implications for the care system at large, but other stakeholders were not included in discussions. The influence of changing resource dependencies between large resource-based organisations and its impact on partnership development was discussed in detail in Chapter 5. Thus, these large resource-based agencies skirted around the process of consensus-building by ensuring that difficult issues were avoided or partners excluded from discussions,

“I'm not sure that [social care funding] was even debated or handled within a formal partnership structure. It was dealt with at a pretty high level between the social services directors and the chief executive of the health authority and others.” CEO, PCG

Indeed, new partnership structures agreed with the LA after 18 months of negotiation set up a Health and Social Care Board outside the HImP structure, deliberately to exclude a broader section of different interests, but ostensibly to improve group dynamics.

The partnership was in effect *non decision-making* as senior staff within the HA and SS kept key issues off the agenda (Bachrach and Baratz 1963; Lukes 1974).

Metrocity – a rubber stamping structure

In Metrocity, the process of consensus-building appeared to be undermined by the structure of the partnership. A number of politicians and officers involved in the HAZ Board, who were used to taking decisions through the joint committee structures, for example, expressed this sentiment. Although power was ostensibly located in the higher tiers of the partnership, the HAZ Board, the real decisions were effectively taken out of the hands of the politicians and community groups and located in the HAZ Steering Group involving key officers who met frequently and had good working relations. Board members felt they were ‘rubber stamping’ decisions as key discussion and debates were held elsewhere. As one member of the HAZ Board noted:

“We’re not making independent strategic decisions on the basis of information and options that are put in front of us, as much as some of the Board would like [...] in terms of really very strongly setting the policy agenda and determining the direction in which the HAZ goes.”

The fairly brisk pace of decision-making added to this sense. The structural and membership design of the HAZ, and lack of voluntary sector involvement in this process (as noted in Chapter 3) also undermined how members of the voluntary sector felt they were able to contribute to debate and decision-making and left some questioning whether partners were ‘singing to the same tune’ (different frames of reference).

In Greenshire, whether consensus was truly reached was also questionable, despite communications being reported as generally good and relations between partners as cordial and enthusiastic. As one Trust director commented in a HImP Board meeting, ‘we talk but don’t listen to one another’, questioning how much the partnership was really engaging in challenging views or debating issues. Talking about whether partners had achieved common aims or an understanding, a DC CEO noted:

“[T]he health authority non-exec directors and the leading members from the local authorities [...] we’ve actually got them in the same room, and

done presentations and workshops for them, and again we get all the words [about common agreement], but then when we try to pick it up and drive it along, somehow they drift apart again.”

Furthermore, the HImP co-ordinator, who was based in the HA, also noted that issues of finance had been deliberately kept out of the HImP until relations were more robust. This was a tactical decision that recognised the importance and thorniness of financial issues between agencies. Nevertheless, it reflected non decision-making.

6.3.2 Really achieving consensus?

Even where respondents noted that there was general agreement or consensus about the objectives of health partnership, this was often only considered as the first step in a process of agreements to be negotiated. It was often considered relatively easy to agree or achieve a consensus about the nature of the problem, the principles, and the desired ‘ends’, in general terms (i.e. improving client benefit). Agreeing a shared vision about the need to improve health and reduce inequalities was so broad and inclusive that it was difficult to argue against it.

“The HImP’s are like motherhood and apple pie. I mean you can’t argue against it, can you?...there’s nothing you can argue against. The issue isn’t what you say, it’s how you achieve it.” Director, VS

It was less straightforward, however, setting the direction, deciding which areas should be a priority and the ‘means’ by which they would be achieved. It was over this second step that conflict had arisen in sites and over which some respondents reported having difficulty resolving. Disagreement had arisen when proposing changes to or development of new services or projects in a wide array of areas (mental health (MH), asthma, exercise, prisons, stroke/coronary heart disease (CHD) prevention etc). A common thread linking these issues was the failure to resolve tensions between different perspectives, values or attitudes of partners, held by professionals, politicians or community representatives. Respondents reported different rationales or interests which were irreconcilable. Inability to find common ground often led to an impasse or a zero-sum outcome (i.e. one party losing out to another) with projects stalling or key partners

withdrawing their support and suspending their membership. Such failure to achieve consensus was noted in all sites.

Asthma – a common lack of consensus

For example, in three sites there was conflict between medical professions and the voluntary sector when considering options for reducing the high levels of asthma in particular communities. Some in the medical profession (i.e. GPs) saw medical solutions ‘for a medical matter’ (i.e. improved access and management of asthma drugs). Others saw solutions in explanations relating to household pollution (dust mites and smoking). However, the voluntary sector saw the cause as related to external pollution (car emissions and high volume of traffic) and, therefore, reductions in asthma lay in wider social solutions.

Failure to see or respect the other partners’ perspective or address their concerns led to a hiatus or tension in relations, ‘blocking consensus’, even leading to ‘blockage of projects’ or withdrawal from the partnership. Commenting on a partnership initiative to reduce dust mites in housing, an Assistant Director of EH in Greenshire said:

“At the moment we cannot get GP involvement; asthma is a medical matter, medical matters are only dealt with by GPs. The problem we have is that as it's a patient-based project we need the medical ethics committee to approve the project, and they will only approve it if we get GP involvement.”

Consensus and National Service Frameworks (NSFs)

For groups working on areas where there was an NSF (i.e. MH, CHD), the first stage and to some degree the second stage of the process of achieving consensus was essentially by-passed as it had already been agreed by the government (as noted in Chapter 3). Discussions and debate were more concerned with implementation within the confines of a narrow framework rather than setting new directions.

Despite these caveats about achieving consensus in HImP and HAZ partnership, respondents did report, nevertheless, some lively ‘grown up’ discussions and debate in some of the more operational groups, in the lower tiers of partnership.

Large groups and decision-making

The influence of partnership structure on communication between individuals and groups and other partnerships was explored earlier. However, in addition to structural complexity, group size was also an issue across all sites and sectors that impacted on communication and decision-making, with nearly a third of coded interviewees (19/61) commenting on this.

As noted in Chapter 1, government guidance stipulated that partnerships should include a wide range of stakeholders from statutory and non-statutory sector. In general, this resulted in HImP and HAZ partnerships having large groups (15-30) (most HImP/HAZ Boards had around 24 members), particularly in rural areas where there were generally more stakeholders (PCGs, DCs and Trusts).

However, for a number of interviewees the size of groups was considered far from optimal for group dynamics. Groups with more than 12 members were considered ‘too big’ and ‘unwieldy’. The more people involved, the more people who wanted their say, pulling the group in different directions. This made it difficult to engage in ‘nitty gritty’ issues at meetings. It also meant that more relationships had to be built, and made it more difficult to sustain a coherent and collective vision – ‘vital work’ when setting up partnerships. The impact of large group size was to slow down the pace of work, retarding decision-making and creating frustration. As one Trust Director noted about large groups:

“That doesn’t mean that everybody’s involved, just having big groups that meet together and have got the right label on them to say that they’re inclusive. And I think this is a criticism here, more than other areas, that we’re - we tend to go for the form, rather than the function.”

Having large inclusive groups presented a dilemma between achieving wider representation beyond usual statutory sector partners and keeping the partnership ‘action orientated’, ‘getting things done’ and delivering the agenda. Many interviewees noted

this tension between inclusiveness (form) and group dynamics (function), particularly partnership co-ordinators.

“We obviously couldn’t have all different voluntary organisations, because there was the practical issue of you know, masses of people sitting round the table, and you’d never get anywhere with it.” Director, LA

One solution to limiting numbers was to have members that acted as representatives from their sector.

However, some interviewees took a more cynical view of the motives for this preference, noting that the arguments for smaller group size were used to restrict their inclusion. Indeed, the rationale of group efficiency did appear to be used mainly by statutory agencies to exclude new partners (the voluntary sector and PCGs).

In Dalesville, for example, where the number of LA districts, and therefore partners, was high, health and social care issues were separated from the HImP, ostensibly to keep the numbers down and the partnership more focused, but some felt it was to keep control over the agenda, as shown in Chapter 5.

An alternative strategy to improve dynamics was for large partnership groups to create working groups, apportioning the agenda into manageable bits, be it a financial or policy issue, with groups open to partners who felt they were able to contribute. In this way, partnership could share the load productively.

Large-sized groups also presented logistical problems around organising meetings and development days etc which everybody could attend, particularly as key people were also likely to be involved in other meetings or busy with the large policy agenda. This could be difficult even in smaller groups:

“[T]rying to arrange a meeting between six or seven people, all in different agencies, all with chocka diaries, you know, simply getting a meeting to talk about an issue, or a project, or you know, it’s – even things like that can be quite difficult.” Manager, PCG

The decision-making and development processes were also slowed down by the problem of logistical co-ordination, especially if not well-managed. The tight timetables and large agenda also undermined the decision-making process, with issues covered in a superficial manner as time-scales did not allow sufficient time to fully engage in debate. However, the presence of a co-ordinator and resources dedicated to supporting the partnership process could greatly improve the interactive dynamics within the partnership and with the external world. This was recognised by nearly a third (19/61) of the coded interviews. Unlike HImPs, HAZ partnerships had funds to resource a co-ordinator. A dedicated co-ordinator could not only play a positive role in managing the partnership but also in developing the process. For example, interviewees recognised the role of a co-ordinator in preventing the partnership becoming a fragmented collective of activities.

“[I]t wasn’t clear to me what the purpose of the HAZ was, or what its aims were, or what it was doing in terms of the wider health economy. What it felt like was that they had a massive amount of money that they couldn’t spend, they didn’t know what to target it on. Part of that was because there was no HAZ director or manager in place.” CEO, PCG

The co-ordinator could also increase the level of engagement between organisations, by uniting the different strands of the partnership, developing clearer partnership structures, making it more obvious as to whom to contact in the partnership. Thus, their presence could increase transparency (i.e. over information and resources) and, therefore, ownership of the agenda. It could also provide direction and leadership to the partnership, influencing its purpose and aims.

“You do need to co-ordinate I think with partnership working, you’ve got to have one organisation or one individual who is going to co-ordinate the whole thing. Without that it can fall to pieces.” Manager, HA

However, it was not just having the position of co-ordinator which made an impact on partnership, it was also having the right person in the post. Having a key individual (of sufficient enthusiasm and seniority) who thought about partner relationships and group dynamics could make a significant difference to progress in achieving the partnership agenda.

In summary, the reality of achieving consensus or a shared frame of reference through discussion and negotiation appeared to be less prevalent than the *belief* that this was a desirable output of partnership. It did appear to take place in a limited fashion. But in general, self-interested concerns, particularly around financial matters, tended to get in the way of relations, as noted in Chapter 5. Some in the voluntary sector felt excluded or marginalized, due to their weak financial position or their structural position in the partnership or size of membership. In one sense, consensus was illusory in some sites as not all stakeholders were involved in resource discussions. Even when there was agreement on the wider purpose of partnership, there were examples of tensions and lack of consensus around the specific direction of action, often with partners with strong views who refused to adjust or compromise their perspective. Here, shared appreciation did not appear to be attained.

Communication and decision-making were also hampered by the structural features of partnership, a consequence of national policy and local context that influenced all sites. Large groups, in particular, presented a challenge to keeping the agenda focused and decision-making moving. The presence of a dedicated, funded co-ordinator could greatly enhance the management and process of partnership, and help avoid collaborative inertia.

Given the apparently limited extent of consensus-building and joint appreciation, what was the nature of the outcomes of HImP and HAZ partnerships? Was innovation evident or were more incremental forms of outcome evident, as Collaboration Theory would suggest? These questions are considered next.

6.4 Achieving synergy or co-ordination

One of the rationales for partnership is the generation of synergy, as expressed in government policy documents on HAZ and HImP partnerships, mostly notably through the use of phrases such as ‘joined-up thinking’, as noted in Chapter 1. Collaboration Theory assumes that radical innovation or synergy emerges out of the constructive exploration of different perspectives held by partners – second order change. The process is different to achieving incremental innovation or co-ordination, where participants’ perspectives are not fundamentally challenged and the existing normative order is only refined or marginally improved – first order change (Roberts and Bradley 1991). The production of co-ordination in partnership is therefore easier to achieve, as the process essentially only requires information exchange, not the resolution of conflict or the negotiation of a new consensus or order. It is through exchange that awareness of resources (financial, informational, technical etc) and their use increases, and more effective deployment can be arranged. The distinction between radical synergy and co-ordination is rarely made in the literature or in public policy, despite the means of achieving these outcomes being different.

This section seeks to explore the nature of outcomes in health partnership and whether their origin derived from first or second order change, and, if so, where and how these processes occurred. A number of questions were put to interviewees designed to elicit whether synergy or co-ordination had resulted from HImP or HAZ partnerships. For example, interviewees were asked directly about whether any new or novel projects or innovation had occurred as a direct result of the partnership, and where and how they had come about. Spontaneous comments which seemed to indicate the generation of synergy were also coded and analysed.

Only a few interviewees made specific reference to the different theoretical outcomes of partnership. One interviewee implicitly summed up the distinction by using the terms ‘joined-up thinking’ and ‘joined-up opportunism’, a categorisation which on closer inspection resembled the difference between synergy and co-ordination. These terms, therefore, were used to frame and explore the data in this section. The process by which these two outcomes were reached is illustrated in Figure 6.1 on page 256, and is

explored in greater detail below. First, the difficulty of linking partnership with process outcomes is examined.

6.4.1 Innovation – a problem of attribution

The vast majority of respondents found it very difficult to attribute outcomes of partnership (projects and initiatives etc) directly to HImP or HAZ partnerships (Barnes, Sullivan et al. 2001).

“It's hard for me to say how much of that joined-upness came from what was the health alliance and how much of it came from other drivers for change really. I'm not quite sure that it's that black and white.” Manager, HP

Several reasons were identified for this. First, there was a plethora of other concurrent government initiatives, such as regeneration partnerships (see Chapter 3 for details), which clouded the water of attribution. Some individuals were involved in these and some projects breached partnership boundaries, for example, by being joint-funded. Also other policy drivers such as the NSF were forcing change in the system through promoting different policy perspectives (eg. encouraging the HA and others to take a more systems-based view or, in the area of older people and MH, pushing prevention, rehabilitation, crisis intervention) or organisational arrangements (i.e. such as including trusts or users and carers in joint care groups). This led to some innovation by encouraging organisations to take risks, but changes in perspectives appeared to be more centrally imposed than locally constructed.

Talking about the areas of drug misuse and MH, one voluntary sector director noted:

“I don't really see much change as a result of the HAZ in those two areas. As far as I can see, it's some things which were going to be done anyway.”

Second, many interviewees claimed that what they were doing was based on what was already in place. The roots of a project may have been several years in the making,

originating from before HImP and HAZ partnerships, perhaps based on former partnership relations between agencies (i.e. HA and SS). Alternatively, a number of respondents noted that many projects were ‘off the shelf’. They had been put together previously but for some reason i.e. lack of funds, were not implemented. The new partnership arrangements presented an opportunity to dust off ‘shelved’ projects or plans. In HAZ partnerships, the availability of funds made it slightly easier for partners to re-examine these projects, ‘re-badging’ them in terms of the health inequalities agenda. HAZ funds acted as a ‘catalyst’ for this process, ‘fast forwarding’ them as new initiatives. It also made it easier to identify projects that were the outcome of HAZ partnership. This was less the case in HImP partnerships. Talking about an innovative palliative care project with the Trust, an Assistant DPH noted:

“To what extent that was really a result of partnership working or it was a result of just having the money and therefore being able to develop these things in areas which I happen to know was a priority, I’m not sure.”

Finally, as noted in Chapter 4, many respondents thought that it was too early in the partnership’s lifecycle to expect, let alone demonstrate, whether the creation of synergy had taken place. Relationships, structures and processes were not sufficiently advanced to achieve this, especially in the newly formed partnership groups (as opposed to those that had evolved from previous arrangements).

6.4.2 Joined-up thinking – radical innovation or synergy

Nevertheless, a handful of respondents were able to attribute what they considered the development of new and novel initiatives or joined-up thinking to partnership in three case study sites. This small number of initiatives (five) (policies and projects) seemed to demonstrate a shift or change in thinking or frame of reference. Joined-up thinking in these cases tended to be in the lower tiers of partnership (rather than at the board level) where many of the members had previously encountered one another from former partnership arrangements such as the JCC. In some cases, joined-up thinking was specifically attributed to the enlargement of membership of these groups, as a result of government policy. New members included Acute Trusts, the voluntary sector and other

professional groups. This brought in new perspectives and ideas into fairly well established groups:

“The HImP has certainly encouraged different professions to come together for the very first time and a different type of networking is now taking place. The example of the Home Safety Group, we are seeing new solutions or new thoughts if not solutions to traditional problems being developed [...] We are skinning proverbial cat in different ways...because we are taking off our professional blinkers and actually recognising that other people can actually make a valuable contribution.” Director, EH

The direction of national policy also helped legitimise different ways of thinking for some groups. The initial emphasis on health rather than health services allowed some partnership groups to broaden the scope of their work, opening up new possibilities.

“We’ve got a new community cardiac rehab programme, provided and led by the leisure department of the boroughs, which is novel, innovative, you know, really good stuff.” DPH

Revealing how increased scope and membership of the learning disabilities group could combine to provide a potent combination, one HImP Co-ordinator said:

“When we gave them encouragement to think about the wider world, they came up with a stream of very simple but very good ideas, for example, for people with learning disabilities [and access to primary and secondary health services]... And because they included now for the first time really the acute sector, suddenly we opened up some of that world and by congregating people into PCGs, we [the partnership] provided them with roots and channels.”

As noted in Chapter 4, this appeared to be more common in staff from HAs and LAs although it was also evident in some staff in Trusts, PCGs and CHCs. However, many still regarded health in fairly narrow terms. It was difficult, therefore, to attribute this change in frame of reference wholly to partnership, rather than to deference to government policy.

The absence of joined-up thinking was also attributed to the over-zealous control exerted by central government over partnership, through funding, timing and timescale, and performance management, as shown in Chapter 3, which restricted innovation and risk taking. As one DPH noted, this was turning the HImP (and the HAZ) partnerships into a 'bureaucratic process' with partners looking to 'tick boxes' rather than provide creative solutions to difficult problems. The nature of relations in partnership was also influenced by the presence of money, which as shown in Chapters 4 and 5, can influence the way partners interact. Thus, the presence of joined-up thinking was not identified by respondents in higher tiers of partnership such as partnership boards. Neither was it identified in newly established groups where relationships and processes were still being developed.

6.4.3 Joined-up opportunism – incremental innovation or co-ordination

Projects or initiatives categorised as joined-up opportunism could be considered to have come about by a fundamentally different process to those identified above. Joined-up thinking required a shift in perspective or frame of reference by partners, through the process of debate, discussion and negotiation. Joined-up opportunism, on the other hand, was more about an exchange of information which led to changes in policies, services or the development of new projects or initiatives but which also left partners' perspectives still intact.

“[W]e've come up with things that we've been doing individually that might be new and fed them into the whole group, rather than the whole group sitting down and trying to think up a new area.” Manager, HA

In contrast to joined-up thinking, respondents cited many more examples of joined-up opportunism or co-ordination in their partnerships. As one HAZ manager noted:

“Where it looks like joined-up thinking it's generally opportunism, rather than strategically thinking and if we did that together that would be good but we'll go and do this and you go and do that [...] the HAZ isn't making that happen.”

Joined-up opportunism, then, came about as a direct consequence of new links or contacts being established between individuals from different departments or agencies by the creation of a health partnership. These new links allowed exchange of information or knowledge about services, practices and policies, leading to the identification of common activities or opportunities for working together.

As one Carers Group Lead noted:

“We've got acute hospital representation on there which is enabling us to take forward much better admission and discharge procedures. Whereas you wouldn't have been able to do that in the old joint planning system because the acute providers would not have actually been within that.”

Although joined-up opportunism resulted in adjustments to work practices and in some cases, the emergence of new initiatives, fundamentally the process of exchange was benign as partners' perspectives remained the same.

6.4.4 Production of joined-up opportunism – formal and informal communication

Earlier in the chapter, two types of new link or communication channel were identified: formal links or communication, which took place within partnership meetings, and informal communication which took place outside this structured environment. This distinction could be identified in the production of joined-up opportunism, as illustrated in Figure 6.1.

In some partnerships, joined-up opportunism resulted from the formal partnership structure which brought together actors who previously had not met. This could occur in the higher and lower tiers of partnership where new groups were being established. It could also result from the design of the structure itself. In Greenshire, for example, the partnership structure was a matrix that linked groups working on disease and determinants of health and care groups. However, as noted earlier in this chapter, formal communication links or channels could have their own dynamic, constraining

discussion or exploration of a topic, and perhaps tending to result in information exchange rather than genuine debate. In this sense, joined-up opportunism might be considered as more akin to co-ordination. This is discussed in more detail below under co-ordination.

Joined-up opportunism was also reported to have occurred outside the formal partnership structures in more informal circumstances, usually by a process of serendipity. It was less common than that generated through the formal process and tended to be located at a local level in the lower tiers of health and regeneration partnerships. For example, in Greenshire and Dalesville local HImP structures brought together individuals in the PCG and DC, resulting in several opportunistic initiatives. Other HAZ sites have noted that informal process have contributed to change (Barnes, Sullivan et al. 2001).

As one PCG CEO noted when talking about the origins of a new initiative being piloted locally between community services and the housing department to enable direct referrals:

“It came out of one of these chats at an [health] alliance meeting. It wasn't part of the formal agenda, but because the parties happened to be there we talked about it. In the meantime, I acted as a broker between the two [agencies].”

The informal production of joined-up opportunism is an outcome not commonly recognised in the literature on collaboration, because, with a few exceptions (Turcotte and Pasquero 2001), the main focus is usually on relatively small, formal partnership structures, not large, rambling, multi-agency structures like HImP and HAZ partnerships.

6.4.5 Co-ordination

As noted above, the innovative outcomes of health partnerships could be mainly categorised as joined-up opportunism. However, health partnerships also resulted in co-ordination which was less innovative. Co-ordination in this sense was more of a pulling together of information or resources that already existed.

Coordination at this level was fairly profuse in partnerships. Indeed, all sites reported an increase in linking of strategic and operational plans beyond that seen in years prior to the HAZ and HImP partnerships. This often involved recognising and signposting other relevant issues to the HImP strategy such as the Community Safety Strategy and local consultation strategies. Such co-ordination was facilitated by the employment of a partnership co-ordinator or secondment to a partner's organisation, both usually dependent on additional funding. With respect to the integration agenda for health and social services, there were common reports of improved co-ordination of planning and operational work. This work was being driven by central government and sharing of information/data, human and financial resources resulted in reduced duplication and clearer or redefined roles between agencies and some new services such as rapid response or crisis prevention teams stemming from the NSF agenda.

However, such co-ordination was far from universal and interviewees from all sites identified 'gaps' or 'holes'. Although health partnerships were credited in all sites as putting health on LAs' agenda, for example, the community strategy and Community Care Plans were still being produced separately, in some cases resulting in a degree of duplication.

"We haven't succeeded in looking at how HImP integrates with community planning processes and all the other plans that they've [LAs] produced."
CEO, DC

As noted in Chapter 3, this was not helped by the abundance of new policy initiatives. Co-ordination was not only lacking between the HA and LA working on the health agenda but also between LAs and between LA departments (i.e. SS and education).

Many LAs were still not joined-up corporately, with departments or units still working in isolation. Work on regeneration, for example, was mixed, with examples mentioned of good and bad co-ordination with the HA on health. In one case, the lack of LA co-ordination on regeneration undermined a partnership bid to get resources.

Mainstream resources for the health agenda were not co-ordinated through a single strategy or budget, as discussed in Chapter 5, apart from some co-ordination of additional monies on specific projects in both HAZ sites.

6.5 Conclusion

This chapter analysed the nature of relations and key processes of collaboration in order to achieve partnership's distinguishing advantage – radical synergy. Previous chapters suggested that requisite processes for collaboration were not developed; central control measures exerted by the government coupled with local contextual factors strongly influenced the nature of interaction between actors, undermining the processual development of partnership. Collaboration Theory was used as a framework to explore further the nature and level of communication between partners and whether dialogue was in evidence, the degree of reported consensus between partners, and the nature and location of partnership outcomes.

It revealed an increase in formal and informal communications between partners, greater than prior to the partnerships' existence. Informal communications were considered an essential adjunct to the functioning of partnership, helping to improve understanding of each other and build relationships outside the stilted dynamics of a formal group.

Nevertheless, the large formal structure, a consequence of national policy and local context, also made communication between actors and groups in the partnerships problematic. The quality of relations was generally described as two-way, open and honest, although the voluntary sector's experience was more mixed and at times opaque. However, despite broad recognition of the need to engage in honest and open

discussion, only a few partnership groups reported a lively and on-going dialogue and debate. Where present, it was in well-established groups in the lower tiers of partnership. Reaching consensus was hampered by the large change agenda, the broad nature of the task and the lack of time of participants. Although consensus appeared to have been reached in sites, closer analysis suggested this was illusory, as certain issues such as financial resources had been kept off the agenda. Even where consensus was reported on the aims of partnership, there was often a lack of consensus over the means and mechanisms of delivery. Decision-making in all sites was also hampered by the large size of partnership groups, again a consequence of national policy and local context. There was some evidence that membership was manipulated, with group size reduced to improve dynamics in some instances. Attributing outcomes directly to one partnership was difficult, due to multiple changes in the system.

Reports of joined-up thinking or radical synergy were few and far between and did not appear to be systematically produced in any study site. As CT suggests, synergy seems to have been generated in partnership groups where there was a possibility of altering an established frame of reference. In the case study sites this appeared to be in the low tiers of partnership in long established groups, where government policy had resulted in increased membership and/or increased freedom to extend the boundaries or scope of work. Here, there appeared to be good relations built on open communications and balanced debate.

However, in newly created groups, relationships were not sufficiently developed at the time of study for the necessary processes to yield synergy. Progress was hindered by central government control as well as by local circumstance, particularly by partnership structure and personalities. Thus, having debate and achieving consensus at the higher tiers of partnership, in particular, was more difficult to achieve. There were no reports of synergetic outcomes.

By contrast, however, many examples of joined-up opportunism or co-ordination were identified. This occurred at all tiers of partnership, even outside the formal structure. As the generation of co-ordination was less process-dependent, essentially based on the

exchange of information rather than changes in frames of reference, it was easier for joined-up opportunism to occur even where communications and personal relationships were not as strong.

Despite increased communication and connectivity, achieving radical synergy in large partnership structures within two to three years of their development appeared difficult. Essential processes required to achieve collaboration were undermined by the national and local context. As large, multi-party collaboratives working on broad health policy domains, HImP and HAZ partnerships appeared to achieve partnership as *co-ordination* rather than partnership as *collaboration*.

The next chapter draws together the findings from this and the previous three chapters to discuss the theoretical and policy implications.

Chapter 7 – Discussion and conclusion

7.1 Introduction

This study has focused on strategic health partnerships set up by New Labour in 1997 to encourage closer working and integration between local agencies, to improve delivery and quality of health and social care, and to address poor population health and health inequalities. HImP and HAZ partnerships had ambitions to involve the voluntary sector in decision-making, thereby strengthening local accountability and democratic participation. These were key themes in the Third Way philosophy which underpinned public sector reforms. Embedded within the government's model of partnership were three concepts of partnership: partnership as *co-ordination*, *collaboration* and *participation*. The development of strategic health partnerships was accompanied by other reforms which embodied other modes of co-ordination, most notably hierarchy, with new infrastructure and the application of indirect control measures to drive partnership's performance. Elements of the former internal market were also retained. This study has sought to understand the nature of strategic health partnerships and the factors that influenced their development, functioning, the behaviour and interaction of partners, and the impact of these factors on the outcomes of partnership. In this way, the study was part formative and part evaluatory, gauging the degree to which the government's ambitions for partnership were achieved.

No other studies of partnership have systematically unpacked the influence of government hierarchy. And yet this study found that central command and control mechanisms were an important influence. Indirect control measures undermined the development, functioning and outcome of partnership. This was not due to the inherent nature of the controls but rather to their structuring and interaction with multiple and shifting commands. In addition, horizontal relations were affected by local context (structural, political, cultural & professional), which in turn, influenced how actors interpreted the costs and benefits of partnership. Two significant factors shaped actors' perceptions: professional perspective and the nature of dependency relations. A key finding was that these factors differentially affected the behaviour and influence of large and small resource-based organisations. Despite sensitivity to the process costs of

partnership, large resource-based organisations such as HAs and LAs were willing to get involved but appeared reluctant to give up control over financial resources, preferring to co-ordinate activity in ‘zones of legitimacy’ – areas of work which did not threaten existing resource dependency relations. Small resource-based organisations, such as those from the voluntary sector, appeared eager to engage in large partnership structures, despite their limited capacity to do so. However, their weak and unstable resource base also appeared to undermine their power to influence decisions on policy and resource allocation. As a consequence, partnership as *participation* was weak, although marginally stronger in HAZ partnerships, where the availability of additional resources not only supported their involvement but also posed less of a threat to existing resource allocation or dependency patterns of statutory agencies.

HIImP and HAZ partnerships primarily showed the characteristics of partnership as *co-ordination*. Exchange of information and resources led to some joining up of local policy and to some opportunistic development of new initiatives. This also occurred as a result of the wider network of relations resulting from the plethora of government-sponsored area-based initiatives, a finding not reported elsewhere. Evidence of partnership as *collaboration*, on the other hand, was rare. The development of radical innovations was reported only in a few instances and in the lower tiers of partnership, in well-established groups with an expanded remit or membership.

The study was unique in developing a framework built around three theoretical perspectives to evaluate health partnership, each focusing on one or more aspects of partnership, linking the policy context with interaction at the meso level and process and outcomes at the micro level. It also clarified the concept of partnership. Other research on HAZ and HIImP partnerships (Judge, Barnes et al. 1999; Barnes, Sullivan et al. 2001; Cole 2003; Sullivan, Judge et al. 2004) has failed to do this, making it impossible to make the distinction between different types of outcomes and the different processes required to achieve them. The study therefore makes a significant contribution to the literature on health partnership.

The remainder of this chapter gives a brief overview of the thesis and the research questions, followed by a more detailed discussion of the findings with reference to the theoretical perspectives. It then focuses on the broader policy context in which partnerships were created and the implications for policy. The strengths and weaknesses of the study are then considered and, finally, future avenues for research are discussed.

7.2 Overview and focus of thesis

This thesis was based on a comparative case study of HImP and HAZ partnerships in four English district HAs. As no single, generally accepted theory of partnership could be identified in the literature, I used different theoretical perspectives from different academic disciplines to study partnership. Three were selected which were key to understanding the context of partnership, the factors driving interaction and behaviour and the management of relations. Each theory also focused on a different aspect of partnership in a complementary way and was able to accommodate one or more notions of partnership projected by the government and its Third Way (see Section 1.2 and 1.3 in Chapter 1).

The governance framework was used to conceptualise the reforms to public services in terms of market, hierarchy and networks. This perspective provided an analytical framework with which to understand the wider policy context as well as to explore the influence of government hierarchy on partnership, particularly the raft of indirect control measures (i.e. targets) introduced to drive and direct its performance.

Resource Dependency Theory (RDT) provided a theoretical framework to analyse and understand the influences on relationships between local partners. This was not only useful for identifying the factors that lead organisations to enter into partnership but also for understanding how partners behave and interact. The symmetry of resource dependency relations is crucial to an actor's influence over resource exchange. Since strategic health partnerships were established to influence policy and resource allocation, this theoretical perspective facilitated an assessment of partnership as *participation*.

Finally, Collaboration Theory (CT) provided a normative framework against which the quality of interactive processes in partnership could be benchmarked and the nature of outcomes assessed. By analysing the factors which influence interaction in partnership as well as the origin of different types of outcome, this perspective allowed an assessment of partnership as *co-ordination* or *collaboration*.

Studies using these theoretical perspectives were reviewed although the evidence relating specifically to health partnerships was generally thin and of varying methodological quality. In addition, the empirical literature on health partnerships in the UK was reviewed. The literature highlighted a number of assumptions and issues relating to: the national and local context in which partnerships operate; the management of interaction between partners; and the structuring of the content of the problem-solving process. These were used to scrutinise the government's approach to partnership and identified three broad areas for enquiry.

First, there was the tension between the indirect control mechanisms imposed by central government to direct and steer partnership and the autonomy required by local partnerships to develop and implement their own programmes in response to local health problems.

Second, there were contradictory assumptions about the nature of local actors, their motivation or willingness to get involved in partnership, and their ability to influence others in partnership. Despite financial incentives for HAZ partnerships and the removal of some legal barriers to resource exchange, the government assumed that actors would be willing to get involved in partnership, particularly the voluntary sector. To encourage involvement, the government promoted a whole systems perspective and social model of health. Theory indicated that this approach which plays both on self-interest and a degree of altruism might be too simplistic. The structure of the environment at macro and meso levels is highly influential on the behaviour and interaction of local actors, whether through the structure of capitalism and the groups and interests it favours (i.e. the medical profession) or the size and structure of resource dependencies and the availability of resources. Nevertheless, the government assumed that partners,

particularly the voluntary sector, would be able to influence decision-making on policy and resource allocation (expressed in its model of partnership as *participation*), despite evidence to suggest that their motivations, resource base and the nature of their dependency relations were very different.

Third, there was an assumption in policy documents that partnership would lead to innovation, synergy or ‘added value’, but without being clear whether these outcomes were different or recognising that management of partnership might lead to different outcomes. The theoretical literature distinguishes between radical and incremental innovation/synergy, suggesting very different processes of production. Producing radical innovation – assumed as the most appropriate process outcome for tackling entrenched social problems – requires participants to reframe their ways of thinking (partnership as *collaboration*). This involves the negotiation of conflicting perspectives and interests and subsequent consensus-building, and is facilitated by conducting these processes in a just and fair manner. Although the government model of partnership emphasised consensus, the key processual attribute – conflict – was overlooked.

These three avenues of enquiry were used to generate four research questions, the findings of which were presented in Chapter 3, 4, 5 & 6.

7.3 Summary and discussion of the findings

This section presents a summary of the findings and discusses their theoretical implications.

7.3.1 *Central control, local autonomy conundrum*

Chapter 3 focused on the impact of vertical command and control mechanisms of central government on the development, functioning and outcome of health partnership, exploring the tension between them. The command mechanisms were the means by which the government articulated and implemented its large-scale reform of the public sector. Commands created new decentralised organisational forms (i.e. PCG/Ts) as well as encouraging and mandating strategic health partnerships. Accompanying policies

promoted a social model of health and a systems-based perspective. These resonated strongly with the population perspective of health held by many public health and health promotion professionals. Data showed that this policy atmosphere provided impetus for forming local strategic health partnerships, and helped move health improvement from a marginal to a mainstream issue. However, the large number of policy commands also placed a large resource burden on statutory organisations. Furthermore, government policy was not as 'joined up' as its rhetoric, with persisting departmentalism resulting in policy incoherence. This led to confusion and duplication, and detracted resources away from building and developing partnerships. The focus of commands also shifted as the hierarchical goals of achieving health improvement were substituted for more health service-orientated goals. It was in this context that the control mechanisms were introduced to drive partnership, based on performance management of output and behavioural targets and standards linked to incentives and sanctions. In practice, the application of performance management was heavily applied and also lacked consistency across the public sector. The shifting policy emphasis towards achieving health service goals was more suited to performance management, and increasing pressure on the government to show delivery of its agenda resulted in an increasingly heavy application of the tool. This drew organisational resources away from developing partnership. While financial incentives seemed to encourage local organisations to form partnerships, changes to funding arrangements (size, timeline and rules), together with draconian sanctions for non-compliance, perversely influenced the nature and quality of partnership outcomes away from health improvement and inequalities reduction.

The case studies showed that health partnerships developed in an environment of multiple, incoherent and shifting command and control mechanisms, which interacted with one another in positive and negative ways, ultimately undermining the original goals for partnership. This negative influence, however, was due more to the magnitude and changing orientation of the command and control mechanisms than to the inherent property of the tools themselves. Thus, the ambitiousness and pace of government reforms placed organisational resources at a premium. The shifting focus placed further constraints on resources as local statutory organisations tried to respond.

Discussion

Sub-optimisation as a tool of hierarchical control can be undermined by *ambiguity* in measuring behaviour and outputs, or subverted by *goal displacement* or *bureaucratic behaviour*, as noted in Chapter 1. The findings of this study show that the use of indirect control measures was effective in directing the focus of partnerships, but on health improvement their impact was weakened in part by their ambiguity. The government's shift in policy towards health services, and the accompanying promulgation of health service targets, with their emphasis on hard process outputs (i.e. waiting times), were instrumental in this. Health service targets were easier to measure and more immediately attributable to the work of partner organisations. By contrast, achieving health improvement targets was more difficult to achieve and demonstrate. The result was a greater emphasis on health service activity with health improvement targets becoming *de facto* a secondary priority, an observation reported in other sites (Exworthy, Berney et al. 2002). There was also a degree of goal displacement as the rules and structure of incentives were changed, with the result that partnerships sought to satisfy the system rather than their original *raison d'être*. The restructuring of incentives and sanctions attached to additional monies added to goal displacement as partnerships were more concerned with spending funding than the quality of the initiatives being developed. The use of indirect control mechanisms paradoxically seemed to limit local success, a finding reported in other HImP and HAZ partnerships (Exworthy, Berney et al. 2002; Sullivan, Judge et al. 2004).

The assumption behind the use of performance management and audit is that benefit reaped from the use of these tools is greater than the cost of imposing such a system (i.e. the collection and analysis of data, the writing and submission of reports) – an assumption that has rarely been evaluated (Power 1997). The transaction costs associated with performance managing additional funds were found to be high. Furthermore, the level of performance management increased dramatically over the study period as more and more targets were introduced by the government. The ability to bear this information/monitoring burden was weakened by the other demands being placed on organisations, which were also drawing precious resources away from the important task of developing partnership relations and local programmes of action. The

(cost) effectiveness of indirect control mechanisms in this environment needs to be questioned.

Nonetheless, indirect control mechanisms were successful in steering behaviour and action in local partnerships. It was the lack of emphasis placed on health improvement service and the perceived lack of sanctions for non-delivery that resulted in greater efforts being placed on health service delivery than on the health partnership agenda. Re-adjusting this balance together with the use of 'harder', intermediate health targets may have resulted in greater progress.

7.3.2 Understanding the local dynamics of partnership

Chapters 4 and 5 used RDT to examine the factors influencing the formation and maintenance of relations as well as the nature of interaction in partnership. Actors appeared to be aware of the costs and benefits of partnership and made a calculative assessment of inter-organisational interaction, a positive assessment then affecting the degree of involvement. The immediate costs of establishing and developing partnership were widely recognised as involving human, administrative and financial resources. Benefits included access to additional funds as well as less tangible, more long-term remuneration such as improved inter-organisational relations (informational) or a better understanding of health issues. There were a number of different factors that appeared to shape their assessment of the costs and benefits of interaction. These related to national policy, local structures and boundaries, local politics and organisational culture and professional training. How they were weighted in actors' calculative assessments appeared to be contingent on their professional perspective. In particular, actors with a broad population health perspective appeared to be more tolerant of the costs and optimistic of the benefits than those with a narrower bio-medical view, who understood health in terms of curing illness in individuals rather than promoting activities to improve health in the population. For those with a bio-medical view, health partnership was perceived as less relevant to their work; marginal benefits were foreshadowed by high transaction costs. Different models of health were allied to different views on where work on health improvement belonged (i.e. its domain): in the NHS or as a multi-agency activity. The resource environment in which the costs and benefits were

weighed up also appeared to be influential, reducing tolerance to the cost of partnership while sharpening focus on the proffered benefits.

Two other factors were shown to be influential on organisations' involvement in health partnership as well as the nature of relations within partnerships: resource base and symmetry of resource dependencies. Together with the factors influencing costs and benefits, these provided a fairly good explanation of the different degrees of organisational involvement in HImP and HAZ partnerships within and between sites.

The nature of involvement in partnership and behaviour of large resource-based organisations with fairly symmetrical resource dependencies appeared to differ from that of smaller organisations with asymmetrical relations. For large organisations with a mandate to participate in health partnership, the degree of involvement appeared to be sensitive to an actor's cost-benefit calculation of the process of partnership. The availability of additional resources in a resource-scarce environment was a sufficient incentive to swing the balance in favour of being involved, even for actors who had a very narrow perspective of health and were more sensitive to process costs (Trusts). However, the degree of influence over resource allocation did not appear to change, with organisations appearing reticent to relinquishing control over core budgets. In one site where there was an attempt to change the underlying resource dependency relationship, relations broke down, creating an atmosphere of low trust between the agencies concerned. Combined with a personality clash between key individuals, the result was an 18-month hiatus in the development of the HImP.

By contrast, involvement in health partnership of small resource-based organisations such as the voluntary sector (but also PCGs, CHCs etc) with asymmetrical resource dependency relations appeared to be driven more by the presence of a weak and unstable resource base. Although aware of the costs associated with the process of partnership, these organisations seemed more willing to bear the costs in order to maintain or increase their access to financial resources or to promote their interests. The asymmetry of resource dependency relations also appeared to influence the nature of relations. The limited access to alternative resources and their heavy dependency on

larger organisations reduced smaller, dependent organisations' ability to exert influence or control over resources within the relationship. Large resource-based organisations seemed reluctant to lose control over core resources or to rectify this situation by strengthening small organisations. That said, where resources were less critical (i.e. additional monies), there was greater willingness to share control or power. The more influential voluntary organisations were the more established ones that had developed Compacts setting out the rules of engagement around funding and activity. Developing such Compacts appeared to strengthen the voluntary sector's influence as large resource-based organisations were more dependent on the sector (i.e. through care provision).

Discussion

The findings of Chapters 4 and 5 appeared to support the general assertions of RDT. Actors assess how inter-organisational relations will impact on their interests, be they financial, political or informational, and manoeuvre to increase resources, reduce uncertainty and, to a degree, preserve autonomy. The costs and benefits of inter-organisational relations appeared to be influenced by a range of contextual factors. Others have identified similar factors – structural, procedural, financial, professional and relational (eg. status and legitimacy) – which influence how actors interpret the value of partnership (Hardy, Turrel et al. 1992). Challis (1988) separates these into structural and behavioural factors and categorises them as either *primary* or *secondary co-ordinative environments*. The driving force in this model is the *secondary co-ordinative environment*, which relates to actors' interpretation of partnership in terms of administrative costs, resources and domain. In this study the perceptions of the costs and benefits of partnership were moulded by ideology, in particular the differing professional perspectives on health, i.e. the bio-medical model or the broader public health perspective. This was a significant influence on how actors saw the domain of health improvement, i.e. whether they perceived health improvement as within the remit of their organisation and therefore of interest. Officers with a narrow bio-medical view tended to see health improvement as either a public health/health promotion or NHS issue, depending on their location. Benson (1975) identifies professional perspective and domain as independent variables which influence network co-ordination. In this study, however, these two factors appeared dependent on one another – ideology

influencing perceptions of domain. While this view concurs with Challis's (1988) collaborative model, it goes further in recognising the role of professional ideology on actors' perception of their *interdependence* on organisations either for resources or in dealing with a social problem. In this study actors holding a bio-medical view were also less likely to recognise their dependence on other organisations in dealing with health improvement. It supports Logsdon's (1991) findings that recognising *interests* and *interdependence* are two essential prerequisites for partnership. The study reaffirms the significance of professional ideology in partnership, particularly as to how they influence these two dimensions. Professions are based on a division of labour and specialisation. Professional ideology often aligns with demarcation of territory, which, in turn, creates interdependencies on others (Logsdon 1991). Historically, different health and social care professions have been accorded different social status and power, derived from the control over, and privileging of certain types of knowledge (Hudson 2003). They have also been afforded different levels of discretion and accountability in their work – a consequence of the complexity and the lack of predictability in their work (Hudson 2002). These three elements – world view, status and autonomy – have a significant influence on how different professionals perceive their interests and interdependence. Encouraging different professions to work in health partnership will require re-negotiation of work domains, in order to establish new but clear boundaries (Rushmer and Pallis 2002). This will require education and socialisation but in an area where there is high societal value attached to medial knowledge, there may be considerable resistance (Hudson 2003).

This study's findings also concur with Challis's (1988) conclusion that large to medium size organisations with a steady resource base and in symmetrical relations are best placed to collaborate, but that such organisations in a resource-scarce environment may be less willing to take risks, co-operating on areas of work which do not fundamentally upset underlying resource dependency relationships, what Scharpf (1978) calls 'zones of legitimacy'. Regardless of the overarching rationale for partnership, greater integration proved threatening to some partners (Lowndes and Sullivan 2004).

This study points to the nature of a partner's dependency relations as a significant factor in its ability to exert influence. The asymmetrical dependency of the voluntary sector on large statutory organisations (HA and SS) appeared to undermine its influence. In a resource-scarce environment, the larger more powerful organisations appeared to exert their dominance over less powerful organisations (Phillips, Lawrence et al. 2000). The voluntary sector's lack of influence in HAZ sites has been noted elsewhere, although credited to its lack of capacity (Sullivan, Judge et al. 2004). However, a few established voluntary organisations did appear to exert greater influence through developing Compacts with larger statutory organisations. By increasing statutory agencies' dependency on them, they were able to transform their relationship towards mutual dependence (Scharpf 1978). Although conscious of the loss of autonomy this might entail, it did not appear to deter the voluntary organisations from using this tactical manoeuvre to access a more stable flow of resources. This finding is supported by Oliver's (1991) research and appeared to contradict some elements of RDT.

Chapters 4 & 5 also identified the role of key individuals in developing partnership. Although the behaviour of all actors was dependent on how they interpreted the relevance and value of partnership, which, in turn, was dependent on their perspective on health, key individuals had specific attributes relating to their position or abilities which gave them undue influence on all elements of partnership.

Their importance has been recognised by other researchers, particularly around the management of the agenda, building relations and driving partnership forward. Where they hold perspectives congruent with the notion of partnership and champion the cause, these *tacticians* (Challis, Fuller et al. 1988), *reticulists* (Webb 1991) *boundary spanners* (Williams 2002) or *social entrepreneurs* (De Leeuw 1999) as they have been called, work horizontally across organisations. To operate effectively they also require legitimacy, a participatory style and a range of political skills which are different from traditional hierarchical, managerial approaches (Huxham and Vangen 2000b; Hudson 2003). Unlike Challis, I have not recognised key individuals in my primary co-ordinative environment as their influence is more concerned with the 'how to do' rather than 'what factor influenced' partnership. Nevertheless, the role of key individuals does

raise some pertinent issues relating to how they should be developed and retained, given their pivotal role, the base of their legitimacy (Hudson 2003), and the different skills required in different types of partnership (strategic or operational) or phases of their development (Williams 2002).

In general, RDT provided a relatively powerful framework for explaining the factors which influence the degree of involvement in partnership and the nature of relations, but, as noted at the end of in Chapter 5, it does not account for actors actively managing the partnership process nor recognise that this might influence the nature of outcomes.

7.3.3 Managing partnership and assumptions about innovation

Chapter 6 focused further on the process and outcomes of partnerships and attempted to link the two using CT. It also identified other influential aspects of the national and local environment as well as providing a richer understanding of interaction in partnership. The chapter examined whether the key process characteristics required for *collaboration* were present. Analysis of interaction showed that the level of formal and informal communication between organisations had increased as a result of partnership but that communications between groups within the larger partnership structure were not very strong. The presence of a dedicated facilitator in groups appeared to improve communication and advance programme development. Although the quality of relations was generally described as open, honest and two-way, only a few groups reported a lively and on-going dialogue and debate. Achieving a real consensus in partnership was undermined by the lack of time, the broad focus of the agenda, and the large size of partnership groups, resulting from the large and ambitious national agenda and local context. Even where consensus appeared to have been achieved, financial resources were kept off the agenda. Attributing outcomes directly to the partnership was also difficult, with most groups using or developing previous work or ideas. Indeed, reports of radical innovation or ‘joined up thinking’ were very few; where it did occur was in established groups in the lower tiers of partnership (rather than in the board or steering groups), which had expanded their size or scope of work in response to government policy. In this environment, reframing seemed more likely. This contrasted with newly formed groups, which did not have sufficiently developed relationships to undergo the

necessary processes to achieve such an outcome. In these groups, co-ordination through a process of information and resource exchange (instead of reframing) was the outcome. Co-ordination or 'joined up opportunism' was also reported as a result of the increased level of informal inter-agency encounters resulting from the proliferation of area-based initiatives – a finding not known to have been reported elsewhere.

Discussion

Such radical innovation is more likely to emerge when negotiations are undertaken in an atmosphere which is open, fair and critical but not judgemental. Although the study identified some characteristics of procedural justice (Eden and Huxham 2001), conflictual dialogue, which arises in the renegotiation of social relations or the framing of perspectives (Hoggett 2003), was not evident. Lack of conflict may not be surprising when critical or core resources were not on the table. The real interests of partners were not at stake. Furthermore, the results revealed that national and local context appeared to undermine the process for achieving radical innovation. The large number of government priorities resulted in large, 'complex' partnership structures (Matka, Barnes et al. 2002) with many sub-groups, making it more difficult to communicate and develop a coherent vision and programme, particularly in rural areas where the large number of organisational boundaries made for very large partnership groups. Indeed, large groups can also obscure decision-making, reducing voluntary sector participation (Lowndes and Sullivan 2004). The role of partnership structure on the process of interaction is little studied. Huxham (2000a) reports that large diverse groups coupled with changing membership and ambiguous and complex structures can undermine the management of interaction and the achievement of collaborative advantage (radical innovation), as was found in this study. Although ambiguity can help achieve consensus over general objectives in partnerships with a broad policy agenda, it can also limit the nature of their outcomes (Turcotte and Pasquero 2001). Ambiguity often precludes conflict, an essential ingredient to the reframing of perspectives and adjustment of interests. On the other hand, Turcotte's (2001) paradox – that increasing group diversity, the very thing that leads to radical innovation, makes achieving this outcome more difficult – was confirmed in the upper echelons of partnership, where relations were new. It was less the case in the more established groups which had expanded their membership. This suggests that the pre-invested social capital in groups may have been

sufficiently robust to cope with conflict resulting from a small expansion in group size and remit. In terms of facilitating and managing processes and relations in (large) groups, the presence of a facilitator/co-ordinator appeared to ensure that co-ordination was more likely to be achieved. There did not appear to be any correlation with radical innovation, perhaps an indication of the time and skills required to generate this outcome.

The generation of 'additional' co-ordination outside the formal partnership structures could be attributed to an increase in 'structural embeddedness' of partnership members in localities – in other words, the extent to which actors' mutual contacts are connected to one another through a third party (Granovetter 1992). The more embedded in local networks, the more an actor knows about all of the other players and the more likely to share values, assumptions and understandings (Hudson 2003). This may be conducive to information flow but may also constrain information or behaviour which seeks to challenge the status quo. It suggests that local networks' development might have an optimal level of embeddedness for generating co-ordination, since social control, particularly in dense networks, is likely to curb radical innovation.

Balance of theoretical perspectives

RDT has taken a prominent role in the findings of this thesis. Although to some extent this was on account of its usefulness in explaining the factors which influence the degree of organisational involvement in partnership, it would be wrong to diminish the accounts of partnership provided by the other two theories. The influence of hierarchy, for example, was probably the most significant factor on partnership's development. While RDT is capable of incorporating notions of vertical dependency into its explanatory framework, it takes a relatively crude approach. Using a framework based on hierarchy enabled greater conceptual clarity when exploring relations between central government and local actors. Similarly, CT provided a means to scrutinise the nature of relations far more closely than RDT. Indeed, both hierarchy and CT provided insights that would not have been possible by using RDT alone. For example, CT called into question reports of consensus which had not arisen through a process of managed conflict. In addition, CT also provided a framework to link process to different types of outcome. This was beyond the scope of RDT. On reflection, the theoretical balance in

this thesis is probably more a reflection of the focus and type of data collection rather than the significance of each theory in understanding partnership.

7.3.4 *Partnership as co-ordination, collaboration and participation*

Given the findings above, an attempt was made to further classify the outcomes of HImP and HAZ partnerships as *co-ordination*, *collaboration* or *participation*, or all three.

Partnership as *co-ordination* in the public sector can be conceptualised as local organisations working together towards a joint outcome (see Figure 1.1 in Chapter 1) through exchanging information and resources. In this way, services are better co-ordinated and duplication reduced, improving efficiency. The creation of large strategic health partnership structures certainly resulted in increased communication and information exchange between agencies, moving health issues up the agenda and resulting in more awareness of other organisations' activities and functions. This led to some joining up of policy at a local level, and to some opportunistic development of new initiatives. The organisational reforms and profusion of other area-based partnerships created a network of local relations which added to serendipitous encounters and led to the development of some additional opportunistic initiatives above and beyond those produced by the formal structures. Incremental innovation, therefore, was the most common outcome of partnership. But even achieving this outcome was undermined by the shifting and heavily applied indirect control mechanisms of government. Under external pressure and deadlines, local partnerships resorted to previously shelved initiatives. Outcomes were also sensitive to the human and financial resources that could be obtained or allocated to the partnership process – a process which in turn was dependent on the national and local context.

The government's model of partnership emphasised the involvement of a wide range of stakeholders, which was considered key to generating innovative responses to difficult and complex social problems. This model echoed CT, which stresses the involvement of key stakeholders, the reframing of perspectives to develop a shared appreciation of the

problem and the development of radically innovative solutions. However, this study found partnership as *collaboration* was far less in evidence than partnership as *coordination*, for the reasons explained above. Achieving collaboration, according to CT, is also dependent on the management of conflicting perspectives and interests, from which new insights and ideas arise. Conflict is harnessed to provide creative solutions which are then taken forward through negotiating consensus. However, Chapter 5 showed how the characteristics of the local context can create conflict, through the actions or behaviour (personality) of key individuals as well as changes to underlying resource dependency relationships. Other sources of conflict commonly identified in partnership are those relating to policies, objectives, priorities, structures and procedures (Markwell 1998). Rather than a positive force, conflict precluded the development of partnership. This finding re-emphasises the point that conflict *per se* is not a source of innovation. It can be viewed as having negative as well as positive consequences for groups, depending on an individual's value system (Buchanan and Huczynski 1997). However, it is the skilful *management* of conflict that gives rise to creativity and change (Markwell 1998).

New Labour also advocated partnership as a way to increase participative democracy and restore local accountability (Sullivan, Barnes et al. 2004). The involvement of the voluntary sector as an equal and influential partner in local decision-making on policy and resource allocation was central to this notion of partnership as *participation*. The findings suggested that participation was not really achieved. Although the voluntary sector was fairly active and involved in HAZ partnerships, this only related to additional monies. When it came to increased voluntary sector involvement in more strategic decisions such as allocations of core or mainstream resources, their influence or power did not appear to have significantly changed. In some instances, the evolving and rather large partnership structures shut out the voluntary sector as their interests or boundaries did not fit with national priorities or local concerns. It was also undermined by the weak link between the HImP strategy and SaFF and JIP groups (Carlisle, Shickle et al. 2004). Lack of strategic support for the sector weakened its position and capacity to engage and appeared to make it cynical about its involvement. Again, government commands appeared to undermine participation with the statutory agencies moving in to promote the government's large, shifting agenda. This resulted in overload and heavily directed

meetings, leaving voluntary sector members questioning their contribution. Similar factors were identified in a study of statutory engagement with communities as well as in other HAZ partnerships (Matka, Barnes et al. 2002; Pickin, Popay et al. 2002). Participation in this sense was more akin to tokenism – what Arnstein (1969) calls placation or consultation. The voluntary sector was only marginally more involved and influential in partnership than prior to the establishment of HImPs. Power differentials remained, with the lack of knowledge, support and resources making it difficult for the sector to be an equal player (Matka, Barnes et al. 2002).

The government reforms, therefore, appeared to result in partnership as *co-ordination* rather than partnership as *collaboration* or *participation*. The orientation of this finding is perhaps not surprising as *participation* is central to creating partnership as *collaboration*. It is not only the presence of alternative perspective or points of view in partnership but the power of the voluntary sector to influence that is crucial to generating radical innovation. Part of the reluctance of statutory organisations to open up to voluntary sector participation was related to the latter's perceived lack of legitimacy (Sullivan, Barnes et al. 2004). Discursive legitimacy – the ability to speak legitimately for issues and other organisations – is an important source of power in partnership (Phillips, Lawrence et al. 2000). However, legitimacy is usually determined by the statutory officers that convene partnership (Gray 1989), and in this study at least, was related in part to the extent to which voluntary organisations/groups were considered representative of their sector. Yet whether any one actor can represent one homogenised sector perspective is questionable. Furthermore, ensuring representativeness through elections depends on having a well developed infrastructure, which, in turn, given the nature of resource dependencies, is likely to depend on the largesse of the statutory agencies. This is likely to re-enforce the statutory sector's power. The ability of the voluntary sector to get heard also depends on the knowledge, confidence and negotiating skills of representatives, which will depend to some extent on access to resources (Lowndes and Sullivan 2004). These issues present significant challenges to involving more excluded and marginal groups in partnership, let alone achieving 'conflict dialogue' required for radical innovation once they are engaged.

7.4 Implications for policy

This study was undertaken when HImP and HAZ partnerships (second wave) were still in their second/third year. The shape of the NHS and of strategic health partnerships has changed significantly since the data in this study was collected, as noted in Section 1.5.3 in Chapter 1. HAs have now been replaced by PCTs, which are now the devolved organisational face of local health purchasing and providing.

The requirement to have a HImP partnership and produce a strategy has ceased. Although HAZ partnerships remain, their future depends on whether government honours its commitment to fund them.

Following the publication of the Wanless reports (2002), emphasis has swung back towards the public health agenda, culminating in the publication of *Choosing Health* (DoH 2004a). The use of partnership as a means to improve population health, reduce inequalities and increase integration between services has continued to be stressed in government policy documents and guidance eg. the creation of children's centres in the children's NSF (DoH 2004b).

However, strategic work on health improvement and inequalities now falls within the remit of Local Strategic Partnerships (LSPs). LSPs provide a single overarching co-ordination framework within which other, more specific local partnerships can operate (DETR 2000b). Unlike HImP and HAZ partnerships, they are primarily LA-led and involve a wide range of stakeholders, including all council departments, in producing the Community Strategy (CS). However the division of responsibilities between the LA and LSPs remains unclear (Atkinson 2004). Initially established in the 20% of most deprived neighbourhoods, LSPs are now widespread.

The emphasis on devolving power to the voluntary sector, local communities/neighbourhoods and patients/consumers in order to increase responsiveness of local services and accountability has continued, in what has become the 'New Localism' (Atkinson 2004). Section 11 of the Health and Social Care Act

(2001), for example, requires PCTs to consult and involve the voluntary sector in the planning and commissioning of services, while the 'Expert Patient' programme places greater emphasis on patients with chronic long-term conditions being involved in decisions concerning their treatment (DoH 2001g). Nationally, an agreement between the NHS and the voluntary sector has set up the National Strategic Partnership Forum to advise ministers on partnership (DoH 2004c). Guidance for LSPs also re-iterates the need to involve the voluntary and private sectors 'to agree a holistic approach to solving problems with a common vision, agreed objectives, pooled expertise and agreed priorities for the allocation of resources' (DETR 2000b). Partnership as *co-ordination*, *participation* and *collaboration* is still very much evident in the policy agenda.

The emphasis on hierarchy has also continued unabated. The use of indirect controls persists strongly, although the number of targets has been rationalised and reduced. PCTs are required to produce a Local Development Plan (LDP) which sets out how it will achieve national priorities and targets within a three-year timeframe. PCTs report to the newly created Strategic Health Authorities (StHA). LAs are required to report on progress in achieving national 'floor targets' and the development of Local Public Service Agreements (LPSAs) in documents such as Community Strategy (University of Warwick, Liverpool John Moores University et al. 2004a). Thus, performance indicators and targets remain firmly embedded as a means of controlling indirectly NHS and LA activity.

Markets as a mode of co-ordination in the NHS have also continued to be developed. Payment by Results (PbR) (DoH 2002c) together with initiatives such as 'Patient Choice' will see the development of a new 'internal market' (DoH 2004d; Greener 2004). Patients, in conjunction with their GPs, will drive change through choosing their preferred hospital for treatment. With money following the patient and prices set centrally, the aim is to establish a competitive acute sector market to drive up quality and performance.

Key elements of government policy have persisted if not been extended since this research was undertaken. Nevertheless, the structure and membership of strategic health

partnerships have been in constant flux as new organisations have been created and policy developed. LSPs are now entering their third year, and are therefore at a similar stage in their development to the health partnerships in this study. The results of this study are therefore still relevant to the prevailing policy environment.

What are the policy lessons of this study? If it is assumed that health partnership is a 'good thing', how should government support it? This is discussed next.

Achieving partnership is not a straightforward process of placing different agencies or organisations in a room and expecting them to work together effectively to tackle difficult social problems. It is resource-intensive and needs an appropriately structured national environment to encourage and develop the local context and management skills in order to get the most out of partnership and avoid collaborative inertia. How might this be encouraged?

National context

The relationship between national government and local agencies (central-local relations) was a significant influence on partnership, affecting the structure, nature and process of interaction and the types of partnership outcome. The structuring of central-local relations therefore needs careful consideration. In this study, the large change agenda used limited organisational resources and diluted focus and efforts directed towards developing partnerships. Ensuring greater coherence in policy (in terms of content and timing) emanating from different government departments would reduce confusion and duplication when implementing policy.

The continued policy emphasis on partnership is to be welcomed in providing continuity and encouragement. This has resulted in the proliferation of partnerships (Jones and Stewart 2004), which, while increasing opportunities for informal co-ordination, has introduced new complexities in terms of organisational roles and governance. Although LSPs now provide a mechanism for co-ordinating these partnerships, the government needs to clarify the division of responsibilities between the LA and LSP, particularly with regard to developing and implementing the CS

(Atkinson 2004), if further fragmentation and partnership ‘silos’ are to be avoided (Skelcher 2004).

The NHS has been beset by continuous revolution over the past 20 years (Webster 2002). As a consequence, organisational structures, boundaries and staff have been in constant flux. This has made it very difficult for actors socially skilled in partnership (i.e. tacticians), let alone regular actors, to form stable inter-organisational relationships and develop and consolidate local knowledge (Jones, Thomas et al. 2004). Indeed, the constant fracturing of organisations has involved major staff changes, increasing the risk of ‘boundary spanner’ loss (Williams 2002). Furthermore, re-negotiation of relationships and structures delays the production of any potential benefits. Any future government reforms will need to be mindful of the impact of restructuring and change on partnership.

Performance management

Performance management of a partnership is more complex and difficult than that of an organisation (University of Warwick, Liverpool John Moores University et al. 2004a). In this study, performance management was successful in directing activity but its heavy-handed application and shifting orientation served to undermine partnerships, impacting on the interaction, process, quality and focus of outputs. It resulted in a ‘top down’ focus on health service activities, emphasising modernisation rather than the health inequalities agenda. A more stable and moderate application of performance management which recognises that change is a long-term process (Lawson, Mackenzie et al. 2002; Matka, Barnes et al. 2002) may have less negative consequences for partnership. Indeed, if strong sanctions were applied to CEOs for not delivering on meaningful health inequalities targets (rather than ‘hard’ health service targets) and if the reporting demands of the centre were not so resource-consuming, its impact on directing activity and delivering desired outcomes might be significant. Performance management is likely to be more effective if it is ‘joined up’ on health inequalities, for example through the LSP structures. This would help to align organisational priorities and agendas (University of Warwick, Liverpool John Moores University et al. 2004a). In this study, the use of different indicators by different government departments, for example, created duplication and was a disincentive to cross-partnership working.

Performance management systems were also at very different stages of development across sites. Currently, StHAs have responsibility for performance management of NHS organisations and HAZ partnerships while several other government units or departments are responsible for monitoring delivery in local government. Developing performance management systems takes time and resource and progress will develop on local circumstance and history. A more considered approach to performance management could have a significant impact on local delivery around health inequalities.

Structuring incentives and sanctions

The government used incentives and sanctions to direct and steer local actors' behaviour. It also promoted a social model of health and a systems perspective. In so doing, its approach was a tacit recognition that local actors were both 'knaves' (primarily motivated by self-interest) and 'knights' (responding with chivalrous intent towards the government's commands) (Le Grand 1997). Structuring policy around knaves to entice them into desired action (or deter certain behaviours), while leaving knights to act with honourable intentions, was reminiscent of the *planned bargaining* framework advocated by Challis (1988).

In this study the use of incentives and sanctions appeared effective in encouraging local actors to enter into partnership, even those with a narrow bio-medical view (i.e. actors from Acute Trusts). Fear of financial sanctions, however, resulted in a needs-led or 'bottom up' local prioritisation process being pushed aside in order to satisfy the centre's demand for spending the money and establishing projects. Further, the attractive pull of funds was also a distraction to participants in partnership, who became overly concerned with the process and fairness of fund disbursement.

Given these findings, the government should continue to be mindful of the factors that influence self-interest when developing policy. These may be social, managerial, political etc, but as was shown in Chapter 5, they also include financial/resource dependency issues.

Through national policy the government is able to influence directly resource allocation and flow in the environment, and therefore resource dependencies, resource base and resource scarcity. Insufficient consideration of these factors has been the undoing of previous policies on partnership (Webb 1991; Nocon 1994). In this study, resource scarcity appeared to make many organisations more introverted and less willing to engage in partnership or take risks when involved.

The government's increased emphasis on markets to improve treatment quality, through initiatives such as PbR, may be detrimental to working in health partnerships. Increasing competition between hospital trusts is likely to reinforce self-interested, inward-looking behaviour as actors focus on their own delivery and guard health and financial information in order to protect their interests.

A key factor affecting the involvement of actors from large resource-based organisations in symmetrical relations was the cost of engaging in partnership, particularly in a resource-scarce environment. Reducing the burden of process or transaction costs through ring-fenced funding may be one way of enhancing involvement.

Incentives, for example, did not appear sufficient for HAs and SS to share or pool budgets; pressure on resources in a resource-scarce environment and symmetry and size of resource base appeared to make these organisations reluctant to jeopardise established relationships. Changing the nature and increasing the size of incentives and sanctions may provide the necessary means to overcome this reluctance. One illustration of this is the Community Care Act (2003). Introduced in 2004, it imposed compensatory financial payments to local hospitals on SS departments that delay discharge. It also recognised (resource) interdependencies and provided additional resources to LAs to enable them to build up convalescence and other support services and to develop smooth patient pathways in advance, thereby paving the way for increasing integration and co-ordination of discharge and intermediate care services (Glendinning and Coleman 2003). Similar approaches may encourage greater innovation and integration between PCTs and SS. However, success will also depend on the government creating

domain consensus through clarifying the respective roles and responsibilities across the health and social care divide (Bridgen 2003).

Strong central control over funding, through the use of ring-fencing, and restricted local delegation of funds helped keep decisions over core resources out of the partnership forum. Having small, delegated, ring-fenced budgets for partnership groups, might help get 'quick wins', improving voluntary sector involvement and influence (University of Warwick, Liverpool John Moores University et al. 2004b).

Encouraging small resource-based organisations

In small resource-based organisations increasing resource stability appeared more prominent in the voluntary sector's (and PCGs') calculations than process costs. Although a weak and unstable resource base appeared to encourage involvement in health partnership, it also limited small resource-based organisations' capacity to participate, and crucially, their capacity to influence local policy and resource allocation.

Voluntary sector involvement

Improving the stability and capacity of the voluntary sector (regarding finance, administration and policy) could make an important contribution to achieving partnership as *collaboration* and *participation*. This has been recognised in other research on health partnerships, including LSPs (Unwin and Westland 2000; Matka, Barnes et al. 2002; Pickin, Popay et al. 2002; University of Warwick, Liverpool John Moores University et al. 2004b). Promoting the negotiation of local Compacts could increase mutual dependency and reduce financial instability, strengthening the sector's influence in decision-making. This, of course, would depend on the degree of resource control assigned to partnership groups (University of Warwick, Liverpool John Moores University et al. 2004b).

In this respect, the recently developed national agreement between the government and the voluntary sector is a positive first step towards encouraging the use of local Compacts (DoH 2004c). These will need to be negotiated locally and pay careful

attention to issues of autonomy as presently a large proportion of voluntary sector resources come from the statutory sector. While increasing the voluntary sector's power and influence through reducing the asymmetry of resource dependency, there is also a risk of loss of independence. This may have implications for achieving partnership as *collaboration*, by limiting the sector's scope, flexibility and willingness to present an alternative, antagonistic perspective and therefore its effectiveness (Unwin and Westland 2000). Local Compacts, therefore, will need to sit within a broader local strategy to develop the voluntary sector (Pickin, Popay et al. 2002), one which has senior support behind it, commitment of resources and recognition of the need to engage the sector at a strategic level and enable it to contribute to the delivery of local priorities (Laverack and Labonte 2000). A survey of HAs in 2000 suggested that only 40% had allocated funds to develop voluntary sector involvement (Shepherd 2000). Besides recognising long-term funding, such a strategy will need to pay attention to process costs, as these are still an important consideration when involving the sector. Availability of travel, administrative and other expenses can help reduce this burden, particularly when involving users/carers and communities. However, nearly a third of NHS Trusts do not have policies on such costs (Ryan and Bamber 2002). A strategy would also need to be mindful that developing Compacts with key voluntary organisations may marginalise smaller voluntary groups and organisations which have not established such strong links with statutory agencies. Certainly findings from this and other case studies note that only a small percentage of potential voluntary organisations are engaged in partnership (Matka, Barnes et al. 2002). Special consideration would also need to be given to community involvement, whose engagement and capacity was found to be particularly weak. LSPs, for example, might use public relations and snowballing techniques as well as dedicated outreach teams to access excluded communities (University of Warwick, Liverpool John Moores University et al. 2004b).

The voluntary sector is far from homogenous in terms of interests and capacity, and a strategy would need to recognise this. The key issue is for statutory agencies to be clear about how and why they are involving voluntary organisations, users/carers and community groups so that they can engage them in a variety of ways in an appropriate

manner (Wilcox 1994). The voluntary sector is more likely to get involved if they can see it to be in their interests (Atkinson 2004).

A strategy would also need to recognise that building voluntary sector capacity to strengthen its participation is not solely an external activity. Statutory organisations also need to review their own structures, policies, resource allocation, information and training provision (Lawson, Mackenzie et al. 2002) so that engaging the voluntary sector becomes a routine way of doing things (NHS Executive, The Institute of Health Services Management et al. 1998). This will also require self-evaluation of the approach adopted (Laverack and Labonte 2000; Atkinson 2004). Without a strategic approach to voluntary sector involvement, there is a grave risk of ‘consultation fatigue’ (Unwin and Westland 2000; Lawson, Mackenzie et al. 2002), and of efforts being viewed as tokenistic.

Other issues

So far the discussion has focused on the premise that actors are primarily self-interested. However, the study also indicates that the boundaries of self-interest are shaped by an actor’s world view. This often reflects their professional perspective, training or workplace practice. Promoting a world view which recognises the value of health partnership and the interdependence of organisations to improve it (such as the broad systems perspective of health) may help shift boundaries i.e. through increasing tolerances towards short-term process costs. A permanent shift in perspectives will require changes to the training of different professional groups working in the health service and local authorities whose work has the potential to impact on health and inequalities. With moves towards practice-based commissioning afoot, efforts will need to include primary care practitioners, particularly GPs, who mainly perceive public health improvement as opportunistic health promotion based around individuals and clinic-based services (Peckham, Taylor et al. 2004). Given the differential status and accountability structures of professional groups (Hudson 2002), government leadership inevitably will be required to drive change. Any shift will also need to clarify roles and responsibilities so as not to inadvertently blur boundaries and weaken domain consensus (Rushmer and Pallis 2002; Bridgen 2003). Efforts would also need to be supported by other national policies which value individuals and organisations that work in

partnership through, for example, rapid promotion in career structures (Challis, Fuller et al. 1988) to ensure behavioural change becomes institutionally embedded.

This study also raised a number of issues relating to the process and outcomes of partnership. Partnership is a resource-intensive and time-consuming process. Participating in and managing large multi-tiered partnerships requires a significant investment of organisational resources (staff, administrative and time) as well as specific management skills, particularly in rural areas where partnerships tend to be large. Investment in the management and administration of partnership, whether nationally or locally, appeared to advance the development of partnership significantly within the study sites. Indeed, radical innovation appeared to occur in groups where there had been considerable prior investment. Developing the functional capacity of partnerships has also been linked to their sustainability (Knight, Smith et al. 2001). Although the government now recognises the role of having ‘delivery managers’ in LSPs (Bright 2005), it is still relying on ‘marginal resourcing’– piggy-backing on the existing workload of managers (Cropper 1996). The government needs to provide flexible mainstream resources to support the capacity of partnership, particularly in an environment where most additional resources are ring-fenced, without re-enforcing the idea of partnership as an add-on. As argued already, government needs to promote partnership as a *modus operandi*, providing support and guidance to ensure that it becomes embedded at a local level through, for example, changes to job descriptions.

Government will also need to consider how to structure policy to increase the likelihood of radical innovation. One of the difficulties of large, multi-stakeholder roundtables is achieving consensus, as a larger number of conflicting perspectives need to be reconciled. However, it is from conflict that radical innovation flows. Although keeping the focus of the health agenda broad can facilitate sign-up to an ambiguous statement of intent, building consensus and commitment to a programme of action is more difficult (Turcotte and Pasquero 2001). Reducing the number of partners through, for example making smaller and, where possible, coterminous boundaries, may facilitate the achievement of consensus. Allowing greater scope for local partnerships to identify their own local health inequalities priorities may appeal more to local interests and

increase commitment. However, both these measures could potentially create other tensions such as the need to accommodate both local and strategic needs in rural areas; a tighter, more local policy focus could reduce the scope of potential innovative solutions. This is not an easy conundrum to solve and ultimately it may require the government to tone down its expectation of partnership.

7.5 Strengths and weaknesses of the study

At the time of writing there are few theoretically-based studies on health and welfare partnership *per se* in the UK; most were empirically-based studies. Of these, however, few employed methodologies appropriate for the study of such a complex social phenomenon as partnership. RDT was one area where there were more theoretically based-studies, but most in this area used quantitative methods, many with poorly validated research tools. The exception was a study by Challis (1988). Although this study sheds significant light on the process of partnership, RDT does not recognise the importance of managing cognitive and social processes in partnership to achieve desired outcomes. Rather, interaction between organisations is ‘determined’ by uncertainty and by the structure of resources and the environment. Indeed, this is one of the criticisms of RDT and the policy network literature.

Much of the research on CT, on the other hand, is based on Action Research (Huxham and Vangen 2000a; Eden and Huxham 2001) and derived from the reflections of researchers following their active interventions in partnership (Ferlie 2001; Meyer 2001). Like its founding theory, Negotiated Order Theory (Strauss, Schatzman et al. 1963; Gray 1989), the focus of CT tends to be on managing the interaction of actors to reach agreement rather than on understanding the wider constraints which influence an individual’s behaviour. Institutionalised behaviour and external conditions such as resource environment and dependency relations are less open to manipulation, and their effect tends to be marginalised in this approach.

This study sought to combine the strengths and weaknesses of both approaches, seeking to understand how structure influences action and interaction and vice versa. The need to understand the ‘duality of structure’ to understand social processes in networks is

advocated by Marsh (1998) and has its roots in Giddens's structuration theory (Hatch 1997a). Likewise, the approach taken in this study was to use these two theoretical perspectives within the governance framework. In this way, the study placed different emphasis on structure and action at different analytical levels (micro, meso, macro), rather than simply trying to develop one single theory of partnership. The framework developed integrates an understanding of what can be done to promote partnership with how it can be managed (Hudson 2003).

Furthermore, using a multiple case study approach, connected to theory, is considered a sign of a well conducted organisational study, particularly when the method is explicit and the researcher independent (Ferlie 2001). Cross-site comparisons enable the development and testing out of theories while multiple cases increase the empirical base and strengthen claims of generalisability. In this study, the use of four sites allowed comparisons on several dimensions (HAZ/non-HAZ, rural/urban). Contrasting differential progress, approaches and issues also facilitated theoretical development. Undertaking the study with less sites, particularly Dalesville, could have limited insight and theory development, particularly with regard to RDT.

Using different theoretical lenses has the advantage of shining a light on the grain and contours of partnership not seen before. Although different perspectives were stronger in explaining different aspects of partnership, I did not specifically seek to find the best overall fit or meld the different theoretical perspectives together to derive a new explanatory framework. This is because the different theoretical perspectives are based on different, often contradictory assumptions. For example, RDT assumes actors are self-interested while a systems approach on which sub-optimisation and CT are founded holds a more altruistic view of human nature. Similarly, inter-organisational conflict is held in a negative light in RDT while CT sees it as a creative force which, if managed properly, can lead to radical innovative solutions. Morgan (1986) has shown how different theoretical perspectives based on different metaphors shape our understanding of organisations in different ways, i.e. machines, brains or political systems. Hatch (1997a) argues for the use of different theoretical perspectives when analysing organisations. She takes a post-modern stance, arguing that no theory can reveal the

‘truth’ as there are no universal criteria to do so. However, different theories or perspectives reveal different kinds of truth *claims*, benefiting different constituencies. Adopting a relativist position is helpful when seeking to understand complex social interaction such as partnership; the different theoretical lenses provide a more holistic image but never one that is wholly clear. Indeed, contradictions or weaknesses of different perspectives can be highlighted by this approach. Similarly, Ferlie (2001) argues that organisational research is good at theorising intermediate processes but weak on understanding group dynamics or the influence of incentives on social action. Organisational studies, therefore, need to draw on complementary theories from other disciplines. Only one other study by De Leeuw (1998) has used more than one theoretical perspective to explore and understand strategic health partnerships.

This study is unique in using multiple theoretical perspectives to specifically evaluate HImP and HAZ partnerships. (Indeed, only a few studies have used any theoretical perspectives at all to study HImP and HAZ partnerships). Doing so allowed different aspects of partnership (interaction between context, mechanism and outcome) to be studied in-depth. The systems model of control in hierarchy enabled the focus on indirect control mechanisms to be sharpened, while RDT focused on the antecedent conditions (national and local) for partnership as well as some aspects of interaction (power-dependency relations). RDT also provided a theoretical link between the micro level of group interaction, power dependency relations at the meso level and the wider political economy (macro level). However, RDT’s deterministic perspective did not capture all the aspects of interaction, particularly those relating to the active management of problem-solving and group relations. CT enabled a closer inspection of these interactional elements, particularly around conflict, negotiation and consensus, and how these link to different types of partnership outcome. This approach gave valuable insights into the formation, development and outcome of partnership, which few other studies to-date have explored. These include a close examination of: the impact of central government command and control (i.e. performance management) mechanisms on partnership structure, interaction, process and outcome; the symmetry of resource dependency and its impact on interaction; and the formation of radical innovation in health partnership. Other theoretical frameworks proposed for the evaluation of partnership are either overly dependent on RDT (Hudson 1987) and the

incumbent weaknesses discussed above, or combine exchange and systems theories but do not reveal how each perspective relates to different levels of analysis (micro, meso, macro) (Loxley 1997) (see Appendix O). More recently, Hudson (2003) has combined Benson's political economy framework with insights from network management but not explicitly for use as a theoretical framework. Other evaluative frameworks distinguish between *process outcomes* and *health outcomes* (Gillies, 1998), but few, if any, make a distinction between radical and incremental outcomes (eg. Glendinning (2002) and Sullivan (2004)).

In sum, the methodology used in this study has developed a unique evaluative framework for studying health partnership. This used multiple theoretical perspectives to analyse partnership at the macro, meso and micro level, linking context with process and process to outcome. Moreover, each theory has provided new insights or deepened theoretical understanding, contributing uniquely to the literature on partnership in three areas. First, it has unpacked the command and control systems of government hierarchy and their influence on different aspects of partnership. Second, it has highlighted the difference between large and small resource-based organisations and their behaviour in strategic health partnership. Third, it has identified the differing influence of formal and informal structures on the generation of joined up thinking and opportunism. As far as the author is aware, these have not been identified or discussed elsewhere. Indeed, very few studies have used a theoretical framework to analyse HImP, HAZ or other health partnerships. Finally, the study has provided greater conceptual clarity on partnership's different dimensions and outcomes, particularly the production of innovation. Others studies on HImP and HAZ partnerships have not done this.

Weaknesses of this study

In any research, its strengths can also be its weaknesses. A criticism often levelled at the use of multiple theoretical perspectives in organisational studies is that no one theory is given preference over another. As no theory (and therefore theories) can represent the 'truth', the point of view is relative to the stance or position from which the theory is conceived and on which it is focused. How can theory be advanced?

A post-modernist (and a symbolic-interpretivist) would argue that knowledge cannot be tested in the real world because the real world is constructed from our experiences, ideas and statements (i.e. theories) about the world. The multiple perspective approach, therefore, provides for diverse possibilities for constructing the world and understanding each other's construction of the world (Hatch 1997a). In this way, the study did not attempt to generate a grand theory of partnership; rather it was a formative study, seeking to understand the complex, social phenomenon of partnership, using theories constructed in different worlds. This study allowed the 'testing' and refinement of each perspective within its respective world. However, the competing and contradictory assumptions of these different worlds can lead to contradictions and paradoxes that in turn can be a source of inspiration or insight.

CT could be considered to be under-represented in this study, used as a normative framework with which to benchmark interaction rather than to develop theory on managing process. Certainly more data and resources dedicated to this area would have allowed a closer inspection of interaction and the management of cognitive and social processes and tighter linkage to partnership outcomes. Given that collaborative inertia is often the main outcome reported in partnerships, a better understanding of the link between process and outcomes would have been beneficial. The study would have clearly benefited from a more thoroughgoing use of CT.

This study was undertaken throughout the second year of HImPs and HAZs, when both types of partnership were still in their formative stage. Their degree of development varied considerably across sites as well as within sites; some sub-groups were already established while other groups consisted of entirely new members. Given the time necessary to develop productive partnerships, the study was undertaken very early on in their life cycle. Although fieldwork was undertaken throughout the year, representing a truncated slice of time, this was a relatively inadequate period to study partnership. A more ideal scenario would have been to follow the development of partnership in fewer sites over several years. This would have enabled a closer and more rigorous study of the impact of performance management or the resource negotiations surrounding the SaFF and JIPs than was possible. It would have also enabled the claims of different

actors to have been explored and tested. That said, other studies of HAZs (and HImPs) recorded some of the same empirical findings as this study. Clearly, the data collection was rich enough for the generation of insights and for the development of different theoretical perspectives. These will need to be substantiated in future studies.

Finally, theoretical and methodological ideals have to be balanced by practical realities such as the resources available, gaining access to sites etc. This study was no exception. Having four case studies facilitated cross-site comparison, but was at the cost of collecting more data from fewer sites. Thus, breadth in case studies limited the time and resources for collecting and analysing interviews, particularly observational and documentary data around the process and outcome of partnership.

7.6 Future areas for research

This study raises a number of questions about partnership and future avenues for research.

Using three theoretical perspectives allows a clearer conceptual analysis of context, process and outcome of partnership. Although this study focused on all three of these elements, most of the emphasis was on the context and process. Less emphasis was on outcome, partly because of resource limitations. Placing more emphasis on understanding interaction and outcome and how these link to process and context may well have provided more robust findings than was possible in this study. For example, it was not able to examine power relations beyond that of authority and control over critical resources. Success in partnership is, in part, dependent on the dispersion of power (Westley and Vredenburg 1997). A third axis of power influential on partnership and not explored in this thesis was discourse (Lawrence, Phillips et al. 1999). Analysing discourse has been used to study the process and outcomes of local regeneration partnerships (Cloke, Milbourne et al. 2000). However, this approach would require a greater focus on the textual content of meetings and on supporting documentary materials. This was beyond the means of this study.

A further area to strengthen would be around the implementation or ‘structuring’ of innovative ideas emerging from negotiations, an area not considered in this study but crucial to the impact of partnership. Gray (1989) argues that successful implementation depends on institutionalisation of partnership arrangements in the early stages of partnership. Phillips (2000) has used ideas from institutional theory to develop a framework for exploring implementation which could be used in conjunction with those used in this study.

In terms of the theoretical perspectives employed in this study, the jury is still out on whether indirect control mechanisms such as targets and performance management can foment the development of partnership and, therefore, more action on health inequalities. With the relentless pursuit of public sector modernisation, with its intensification of performance management, there is continued scope to investigate its influence on the functioning and outcomes of LSPs and other partnership arrangements.

Similarly, this study supports the supposition from RDT that in a situation of resource scarcity, large resource-based organisations such as HAs and SS may limit areas of work so as not to upset the underlying dependency relationship. This raises questions about the way in which greater resource exchange and integration between SS and PCTs should be encouraged. Challis (1988) argues that operating in a less resource-restricting environment may well be more conducive to collaboration as the risk of failure is more bearable. Another approach suggested by RDT might be the use of targeted incentives around the development of integrated projects. Either way these questions are for empirical investigation.

With respect to Collaboration Theory, this study has raised questions about the production of radical innovation, a fairly elusive outcome in this study. Collaboration Theory was used as a framework to guide analysis; however, a more detailed exploration of its production is warranted, particularly in large, formal, multi-agency partnerships where this issue is poorly understood. This would require a more in-depth study of processes and conditions involved in its production and would need to be linked to the nature of the problem domain.

The current policy environment provides some opportunity to explore these issues with respect to health partnerships, with LSPs being the new forums for addressing social exclusion and health inequalities in deprived local neighbourhoods.

Further studies of health partnership should be of greater duration than one year. This study suggests that research would benefit from data collection over the complete lifetime of a partnership, or at least several years.

7.7 Concluding remarks

This study has sought to understand the nature and function of health partnership in England, focusing on HImP and HAZ partnerships in four case study sites. Reflecting the rationale for partnership expressed in the government's Third Way rhetoric and policy documents, it developed a notion of partnership as *co-ordination*, *collaboration* and *partnership*. These dimensions were explored using a framework built around three theoretical perspectives on inter-organisational relations: Governance Theory, Resource Dependency Theory and Collaboration Theory. The analysis revealed that despite government promoting partnership as a panacea for tackling health inequalities and service delivery over market and hierarchical forms of co-ordination, in reality elements of hierarchy remained strong throughout the reforms. These combined with the large national reform agenda and local context to undermine the development of partnership as *collaboration* as well as partnership as *participation*. Rather, partnership as *co-ordination* was the main outcome of government reform. This raises the question of whether partnership as *collaboration* is a chimera, and whether expectations should be toned down. The analytical framework used to analyse health partnership yielded valuable insights which other studies on HImP and HAZ partnerships, due to lack of theoretical base, did not identify. Furthermore, the causal 'mechanisms' embodied in the theoretical framework laid a more solid foundation on which to build policy recommendations. It has also highlighted a number of avenues for future research which will deepen our understanding of health partnership.

Bibliography

- Abbott, S. and S. Gillam (2000). HImPs. Trusting to luck. *Health Service Journal* 110(5705): 24-5.
- Abbott, S., S. Shaw, et al. (2004). Comparative analysis of health policy implementation. The use of documentary analysis. *Policy Studies* 25(4): 259-266.
- Abercrombie, N., S. Hill, et al. (1994). *Dictionary of Sociology*: Penguin.
- Alder, P. A. and P. Alder (1998). *Observational techniques. Collecting and Interpreting Qualitative Materials*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage.
- All Party Parliamentary Group on Primary Care and Public Health (2000). Report of an enquiry into Health Improvement Programmes. London, House of Commons: 9.
- Allen, P. W. L. (2000). Legal and Economic Aspects of Contracts in the NHS Internal Market. *London School of Hygiene and Tropical Medicine*, University of London.
- Allison, G. (1971). *Essence of Decision: Explaining the Cuban missile crisis*. Boston: Little, Brown.
- Altheide, D. L. and J. M. Johnson (1998). *Criteria for assessing validity in qualitative research. Collecting and Interpreting Qualitative Materials*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage: 283-312.
- Amery, J. (2000). Interprofessional working in Health Action Zones: how can this be fostered and sustained? *Journal of Interprofessional Care* 14(1): 27-30.
- Arblaster, L., J. Conway, et al., Eds. (1998). *Achieving the impossible. Interagency collaboration to address the housing, health and social care needs of people able to live in ordinary housing*. Community care into practice series. Bristol: The Policy Press.
- Ariño, A. and J. D. L. Torre (1998). Learning from failure: towards an evolutionary model of collaborative ventures. *Organization Science* 9(3): 306-25.
- Arnstein, S. R. (1969). A Ladder of Citizen Participation." *Journal of the American Planning Association* 35(4): 216-224.
- Arora, S., A. Davies, et al. (1999). Developing Health Improvement Programmes. Lessons from the first year, King's Fund.
- Arora, S., A. Davies, et al. (2000). Developing Health Improvement Programmes: challenges for the new millennium. *Journal of Interprofessional Care* 14(1): 9-18.
- Ashton, J., Ed. (1992). *Healthy Cities*. Milton Keynes, Philadelphia: Open University Press.

- Asthana, S., S. Richardson, et al. (2002). Partnership Working in Public Policy Provision: A framework for evaluation. *Social Policy and Administration* 36(7): 780-795.
- Atkinson, P. and A. Coffey (1997). *Analysing documentary realities. Qualitative research. Theory, method and practice*. D. Silverman. London, Thousand Oaks, New Delhi: Sage: 45-62.
- Atkinson, R. (2004). *Creating the city region in the UK: the challenge of neighbourhoods. Paper presented at a Regional Studies Association conference*. City Regions: Creating new urban futures? London.
- Audit Commission (1994). *Finding a Place: a review of mental health services for adults*. London: HMSO.
- Bachrach, P. and M. S. Baratz (1962). Two faces of power. *American Political Science Review* 56: 947-52.
- Bachrach, P. and M. S. Baratz (1963). Decisions and nondecisions: an analytical framework. *American Political Science Review* 57: 641-51.
- Barnes, M., E. Matka, et al. (2003). Evidence, understanding and complexity: evaluation in non-linear systems. *Evaluation* 9(3): 265-284.
- Barnes, M., H. Sullivan, et al. (2001). Building capacity for collaboration: the national evaluation of Health Action Zones. Context, strategy and capacity. Initial findings from the strategic level analysis. HAZ strategic overview report. Birmingham, University of Birmingham.
- Bartunek, J. M., P. G. Foster-Fishman, et al. (1996). Using Collaborative Advocacy to Foster Intergroup Cooperation: A Joint Insider-Outsider Investigation. *Human Relations* 49(6): 701-33.
- Barzelay, M. (2001). *Conclusion. The New Public Management. Improving research and policy dialogue*. California: Regents of the University of California Press: 156-171.
- Bauld, L., K. Judge, et al. (2000). Health Action Zones in Transition: Progress in 2000. The National Evaluation of Health Action Zones. Glasgow, University of Glasgow.
- Becker, H. S. and B. Geer (1972). *Participant observation and interviewing: a comparison. Symbolic Interaction: a reader in social psychology*. J. G. Manis and B. N. Meltzer. Boston: Allyn and Bacon Inc.
- Beecham, L. (2000). NHS Modernisation teams announced. *British Medical Journal* 320: 894.
- Bennington, J. (2000). The Modernization and Improvement of Government and Public Services (ed.). *Public Money and Management*(April-June): 3-8.

- Benson, J. K. (1975). The Interorganizational Network as Political Economy. *Administrative Science Quarterly* 20: 229-249.
- Benson, J. K. (1982). *A Framework for Policy Analysis. Interorganizational coordination. Theory, research and implementation*. D. L. Rogers, Whetten D. A. Ames, Iowa: Iowa State University Press: 137-176.
- Blair, T. (1998). *The Third Way. New Politics for the New Century*. London: The Fabian Society.
- Bloxham, S. (1996). A case study of inter-agency collaboration in the education and promotion of young people's sexual health. *Health Education Journal* 55(4): 389-403.
- Bogason, P. and T. A. J. Toonen (1998). Introduction: Networks in public administration. *Public Administration* 76(Summer): 205-227.
- Börzel, T. A. (1998). Organizing Babylon - on the different conceptions of policy networks. *Public Administration* 76(Summer): 253-273.
- Bradach, J. L. and G. E. Eccles (1991). *Price, authority and trust: from ideal types to plural forms. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage: 277-292.
- Bridgen, P. (2003). Joint planning across health/social services. *Local Government Studies* 29(3): 17-31.
- Bright, J. (2005). Neighbourhood Renewal and Performance Improvement. *Haringey Strategic Partnership*. Tottenham Hotspur Football Ground, London, Neighbourhood Renewal Unit, Office of the Deputy Prime Minister.
- Britten, N. (1995). Qualitative interviews in medical research. *British Medical Journal, London* 311(6999).
- Bryman, A. (1988). *Quantity and Quality in Social Research*. London, New York: Routledge.
- Bryman, A. (1989). *Research Methods and Organization Studies*. London, New York: Routledge.
- Buchanan, D. and A. Huczynski (1997). *Choosing the appropriate conflict management technique (1977). Organizational Behaviour: An Introductory Text. Integrated readings*. Hemel Hempstead: Prentice Hall Europe: 320-328.
- Bulmer, H. (1969). *Symbolic Interactionism: Perspective and Method*. Prentice-Hall.
- Burgess, R. G. (1991). *Keeping field notes. Field research: a sourcebook and field manual*. R. G. Burgess. London: Routledge: 191-194.

- Burke, W. W. (1995). *Networking. The Blackwell Encyclopedic Dictionary of Organizational Behavior*. N. Nicholson, R. S. Schuler and A. H. Van de Ven. Cambridge, Massachuetsits: Blackwell Business: 346-348.
- Cadbury, R. (1993). The partnership challenge: the need for public partnership in urban regeneration. *Public Policy Review* 1(3): 11-12.
- Cameron, M. and S. Cranfield (1998). Unlocking the potential. Effective partnerships for improving health. London, NHS Executive North Thames.
- Carlisle, J., D. Shickle, et al. (2004). An audit of the process of developing the Health Improvement Programme into the Strategic and Financial Framework in two Health Authorities. *Health Services Management Research* 17: 211-16.
- Carruthers, I., J. Shapiro, et al. (1999). Improving HImPs. The early lessons, Health Services Management Centre, School of Public Health, University of Birmingham.
- Cassell, J. (1980). Ethical Principles for Conducting Fieldwork. *American Anthropologist* 82: 28-41.
- Challis, D. (1989). Supporting frail elderly people at home: The Darlington Community Care Project. Kent, PSSRU.
- Challis, L., S. Fuller, et al. (1988). *Joint Approaches to Social Policy: rationality and practice*. Cambridge, New York, New Rochelle, Melbourne, Sydney: Cambridge University Press.
- Chancellor of the Exchequer (1998). *Modern Public Services for Britain: Investing in Reform. Comprehensive Spending Review: New Public Spending Plans 1999-2002*. London: The Stationery Office.
- Cloke, P., P. Milbourne, et al. (2000). Partnership and Policy Networks in Rural Local Governance: Homelessness in Taunton. *Public Administration* 78(1): 111-133.
- Cole, M. (2003). The health action zone initiative: lessons from Plymouth. *Local Government Studies* 29(3): 99-117.
- Collins, C. (1994). *Management and organization of developing health systems*. Oxford, New York, Tokyo: Oxford University Press.
- Community Care Act (2003). *Community Care (Delayed Discharges etc) Acts 2003*.
- Cook, K. S. (1982). *Network Structures from an Exchange Perspective. Social structure and network analysis*. P. V. Marsden and N. Lin. Beverly Hills, London, New Delhi: Sage: 177-199.
- Cooksey, J. and R. Krieg (1996). Metropolitan Health Policy Development: Barriers to implementation. *Journal of Public Health Policy* 17(3): 261-274.

- Cornish, Y., R.-H. Chris, et al. (1997). Review of Health of the Nation in North Thames. Tunbridge Wells, UK, South East Institute of Public Health.
- Costongs, C. and J. Springett (1997). Joint working and the production of a City Health Plan: the Liverpool experience. *Health Promotion International* 12(1): 9-18.
- Craig, G. and M. Taylor (2000). *Local government and the third sector: papering over the cracks?* Paper prepared for the Fourth ESRC Research Seminar on New Labour and The Third Way in Public Services: New Forums of Partnership, University of York.
- Crawshaw, P., R. Bunton, et al. (2003). Health Action Zones and the problem of community. *Health and Social Care in the Community* 11(1): 36-44.
- Croft, S. and P. Beresford (1996). *The politics of participation. Critical Social Policy. A Reader. Social Policy and Social Relations*. D. Taylor. London, Thousand Oaks, New Delhi: Sage: 175-198.
- Crompton, R. and G. Jones (1988). *Researching white collar organisations: why sociologists should not stop doing cases studies. Doing research in organizations*. A. Bryman. London: Routledge: 69-82.
- Cropper, S. (1996). *Collaborative working and the issue of sustainability. Creating Collaborative Advantage*. C. Huxham. London, Thousand Oaks, New Delhi: Sage: 80-100.
- Cuff, E. C., W. W. Sharrock, et al. (1990). *Perspectives in sociology*. London, New York: Routledge.
- Dalesville Health Authority (1999). Dalesville Health Improvement Programme 1999/2000-2001/2002. Dalesville, Dalesville Health Authority.
- David, J. and L. Zakus (1998). Resource dependency and community participation in primary health care. *Social Science & Medicine* 46(4-5): 475-494.
- Davies, J. and et al. (1993). Healthy alliances: a study of inter-agency collaboration in health promotion, London Research Centre, South West Thames Regional Health Authority.
- De Leeuw, E. (1999). Healthy Cities: urban social entrepreneurship for health. *Health Promotion International* 14(3): 261-69.
- De Leeuw, E., E. Abbema, et al. (1998). Healthy Cities Project. Second Phase Policy Evaluation. Maastricht, WHO.
- Delaney, F. (1994). Making connections: research into intersectoral collaboration. *Health Education Journal, London* 53(4): 474-485.
- Delaney, F. and G. Moran (1991). Collaboration for health: in theory and practice. *Health Education Journal* 50(2): 97-99.

- Delaney, F. G. (1994). Muddling through the middle ground: theoretical concerns in intersectoral collaboration and health promotion. *Health Promotion International* 9(3): 217-225.
- Denman, S. (1994). Do schools provide an opportunity for meeting the health of the nation targets? *Journal of Public Health Medicine* 16(2): 219-224.
- DETR (1998). Modern Local Government: In Touch with the People. London, Department of the Environment, Transport and the Regions. Cm 4041.
- DETR (2000a). Regional Co-ordination Unit, Collaboration and co-ordination in area-based initiatives, Second research working paper. Rotherham., Department of the Environment, Transport and the Regions.
- DETR (2000b). Local Strategic Partnerships. London, Department of the Environment, Transport and the Regions.
- Dixon, J. (2001). Health care: Modernising the Leviathan. *The Political Quarterly* 72(1): 30-38.
- DoH (1987-2001). Bed Availability and Occupancy, England (KHO3, KH03a, KH05, KH09, KH12 and KH14). London, Department of Health.
- DoH (1992). *The Health of the Nation: a strategy for health in England*. London: HMSO.
- DoH (1993). *The health of the nation: one year on. A report on the progress of the health of the nation*. London: HMSO.
- DoH (1996). *Public health common data set 1996*. England: Department of Health.
- DoH (1997). *The new NHS: Modern, Dependable*. London: Stationery Office.
- DoH (1998a). *The Health of the Nation - a policy assessed*. London: Stationery Office.
- DoH (1998b). *HSC 1998/159: LAC(98)22. Modernising Health and Social Services. National Priorities Guidance 1999/00 - 2001/02*. London: Department of Health.
- DoH (1998c). *Partnership in Action. New opportunities for joint working between health and social services. A discussion document*: Department of Health.
- DoH (1998d). *A first class service: quality in the new NHS*. London: Department of Health.
- DoH (1998e). *Modernising Social Services. Promoting independence, Improving protection, Raising standards*. London: The Stationery Office.
- DoH (1998f). *Smoking kills: a White paper on tobacco*. London: The Stationery Office.
- DoH (1998g). *Tackling drugs to build a better Britain: the government's ten-year strategy for tackling drugs misuse*. London: The Stationery Office.
- DoH (1998h). *The new NHS: Modern and Dependable. A national framework for assessing performance*. London: Stationery Office.

- DoH (1998i). HSC 1998/205. Health Authority Revenue Allocations 1999/2000. London, Department of Health.
- DoH (1998j). *HSC 1998/167. Health Improvement Programmes. Planning for Better Health and Better Health Care*: NHS Executive.
- DoH (1999a). *Saving lives: Our Healthier Nation: a contract for health*. London: Stationery Office. Cm 4386.
- DoH (1999b). A National Service Framework for Mental Health. London, Department of Health.
- DoH (1999c). *Tackling Teenage Pregnancy*. London: Department of Health.
- DoH (1999d). *HSC 1999/152: LAC (99) 2. Saving Lives: Our Healthier Nation White Paper and Reducing Health Inequalities: an Action Report*: NHS Executive.
- DoH (1999e). HSC 1999/243. Health Authority Revenue Case Limits 2000/01. London, Department of Health.
- DoH (1999f). *HSC 1999/244: LAC (99)39. Planning for Health and Health Care. Incorporating guidance for Health and Local Authorities on Health Improvement Programmes, Service and Financial Frameworks, Joint Investment Plans and Primary Care Investment Plans*: NHS Executive.
- DoH (2000a). The NHS Plan. A plan for investment. A plan for reform. London, HMSO. Cm 4818-I.
- DoH (2000b). A National Service Framework for Coronary Heart Disease. London, HMSO.
- DoH (2000c). HSC 2000/034. Allocations, Planning and Priorities, NHS Executive: 4.
- DoH (2000d). *HSC 2000/011: LAC 2000/10. Commencement of Sections 29 and 30 of the Health Act 1999*: NHS Executive.
- DoH (2000e). *HSC 2000/010: LAC (2000)9. Implementation of Health Act Partnership Arrangements*: NHS Executive.
- DoH (2001a). *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*. London: Department of Health.
- DoH (2001b). *Shifting the Balance of Power within the NHS. Securing Delivery*. London: HMSO.
- DoH (2001c). Health Improvement and Modernisation Plans (HIMPs): Requirements for 2002, NHS Executive, Leeds.
- DoH (2001d). A National Service Framework for Older People. London, HMSO.
- DoH (2001e). *New Planning Framework*. London: HMSO.

- DoH (2001f). *Valuing People. A New Strategy for Learning Disability for the 21st Century.* A White Paper presented to Parliament by the Secretary of State for Health by Command of Her Majesty. London, HMSO. Cm 5086.
- DoH (2001g). *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century.* London: Department of Health.
- DoH (2002a). *Delivering the NHS Plan. Next Steps on Investment, next steps on reform. Presented to Parliament by the Secretary for State for Health.* London: HMSO.
- DoH (2002b). *Keys to Partnership: Working Together to make a Difference in People's Lives.* <http://www.valuingpeople.gov.uk/documents/PartnershipGuidanceFull.pdf>, Department of Health. 2002.
- DoH (2002c). *Reforming NHS Financial flows. Introducing Payment by Results:* Department of Health.
- DoH (2003). *Tackling Health Inequalities. A Programme for Action:* Department of Health.
- DoH (2004a). *Choosing Health: making healthier choices easier. Working in partnership across government with people, their communities, local government, voluntary agencies and business:* Department of Health.
- DoH (2004b). *Executive Summary, National Service Framework for Children, Young People and Maternity Services.* London, Department of Health.
- DoH (2004c). *Making Partnership Work for Patients, Carers and Service Users. A Strategic Agreement between the Department of Health, the NHS and the Voluntary and Community Sector.* London: Department of Health.
- DoH (2004d). *The NHS Improvement Plan: Putting People at the Heart of Public Services.* London: Department of Health.
- Donaldson, C. and K. Gerard (1993). *Markets and Health Care. Economics of health care financing: the visible hand.* Basingstoke: Macmillan.
- Douglas, R. (1998). *A framework for healthy alliances. Alliances in health promotion: theory and practice.* A. Scriven. London and Basingstoke: Macmillan.
- Ebers, M. (1997). *Explaining Inter-organizational Network Formation. The Formation of Inter-organizational Networks.* M. Ebers. Oxford: Oxford University Press: 3-40.
- Eden, C. and F. Ackerman (2001). *Group Decision and Negotiation in Strategy Making. Group Decision and Negotiation* 10: 119-140.
- Eden, C. and C. Huxham (2001). *The negotiation of purpose in multi-organizational collaborative groups. Journal of Management Studies* 38(3): 373-91.

- Ellis, D. (2000). Letter to Community Living magazine from David Ellis at the Department of Health (12/12/00) on Independent Living Funds and people with learning difficulties.
- Elmore, R. E. (1997). *Organizational models of social program implementation. The Policy Process*. M. Hill. London: Prentice Hall, Harvester Wheatsheaf: 241-71.
- Elston, J. and N. Fulop (2002). Perceptions of partnership. A documentary analysis of Health Improvement Programmes. *Public Health* 116: 207-213.
- Engel, C. (1994). *Functional anatomy of teamwork. Going inter-professional: working together for health and welfare*. A. Leathard. London and New York: Routledge: 67-89.
- European Observatory on Health Care Systems (1999). *Health Care Systems in Transition. United Kingdom*. Copenhagen: WHO Regional Office for Europe.
- Evans, D. and A. Killoran (2000). Tackling health inequalities through partnership working: learning from a realistic evaluation. *Critical Public Health* 10(2): 125-40.
- Exworthy, M., L. Berney, et al. (2002). "How great expectations in Westminster may be dashed locally": the local implementation of national policy on health inequalities. *Policy and Politics* 30(1): 79-96.
- Exworthy, M., M. Powell, et al. (1999). The NHS: Quasi-market, Quasi-hierarchy and Quasi-network? *Public Money and Management*(October-December): 15-22.
- Fasel, D. K. (2000). *Partnering in Action. A guide for building successful collaboration across organizational boundaries*. Oxford: How To Books.
- Ferlie, E. (2001). *Organisational studies. Studying the organisation and delivery of health services. Research methods*. N. Fulop, P. Allen, A. Clarke and N. Black. London and New York: Routledge: 24-39.
- Ferlie, E., L. Ashburner, et al. (1996). *The New Public Management in Action*. Oxford: Oxford University Press.
- Ferlie, E. and G. McGivern (2003). Relationships between health care organisations: a critical overview of the literature and a research agenda. A report for the NHS Service Delivery and Organisation National R & D Programme. London, Imperial College.
- Ferlie, E. and A. Pettigrew (1996). Managing through networks: some issues and implications for the NHS. *British Journal of Management* 7(Special Issue): S81-S99.
- Finlayson, A. (1999). Third Way Theory. *The Political Quarterly* 70(3): 271-279.
- Fleisher, C. S. (1991). Using an Agency-Based Approach to Analyze Collaborative Federated Interorganizational Relationships. *Journal of Applied Behavioral Science* 27(1): 116-130.

- Flick, U. (1992). *Triangulation revisited: strategy of validation or alternative?* Journal of the Theory of Social Behaviour, Minneapolis/St. Paul, New York, Los Angeles, San Francisco: West Publishing Company.
- Flynn, R., Williams G., Pickard S. (1996). *Markets and networks. Contracting in community health services*. Buckingham, Philadelphia: Open University Press.
- Fontana, A. and J. H. Frey (1998). *Interviewing. The art of science. Collecting and Interpreting Qualitative Materials*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage: 47-78.
- Forsyth, B. and P. Winterbottom (2002). Beds, budgets and burdens: learning disability expenditure v. workload across English health authorities. *British Journal of Psychiatry* 181: 200-207.
- Francis, J., R. Levačić, et al. (1991). *Introduction. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage.
- Fulop, N., J. Elston, et al. (2000). Lessons for health strategies in Europe: the evaluation of a national health strategy in England. *European Journal of Public Health*(10): 11-17.
- Funnell, R., K. Oldfield, et al. (1995). *Towards Healthier Alliances. A tool towards planning, evaluating and developing healthier alliances*: Health Education Authority and Wessex Institute of Public Health Medicine.
- Geddes, M. (1997). *Partnership against poverty and exclusion? Local regeneration strategies and excluded communities in the UK*. Bristol: The Policy Press.
- Geller, R. J. (2001). The first year of Health Improvement Programmes; views from Directors of Public Health. *Journal of Public Health Medicine* 23(1): 57-64.
- Gerring, J. (2001). *Causation. Social Science Methodology: A Criterial Framework*: Cambridge University Press: 128-151.
- Gerring, J. (2001). *A Criterial Framework. Social Science Methodology: A Criterial Framework*: Cambridge University Press: 19-31.
- Giddens, A. (1998). *The Third Way. The Renewal of Social Democracy*. Cambridge: Polity Press.
- Gillies, P. (1998). Effectiveness of alliances and partnerships for health promotion. *Health Promotion International* 13(2): 99-119.
- Gillon, R. (1985). *An Introduction to Philosophical Medical Ethics. Philosophical Medical Ethics*. Chichester: John Wiley & Sons.

- Gillon, R. (1994). Medical ethics: four principles plus attention to scope. *British Medical Journal* 309: 184-188.
- Glaser, B. and A. Strauss (1967). *The discovery of grounded theory*. Chicago: Aldine Publishing.
- Glendinning, C. (2002). Partnership between health and social services. Developing a framework for evaluation. *Policy and Politics* 30(1): 115-127.
- Glendinning, C. and J. Clarke (2000). *Old wine, new bottles? Prospects for NHS/local authority partnerships under 'New Labour'*. Paper prepared for the ESRC seminar on 'The Third Way in Public Services - Partnership', University of York.
- Glendinning, C. and A. Coleman (2003). Joint working: The health service agenda. *Local Government Studies* 29(3): 51-72.
- Granovetter (1985). Economic action and social structure - the problem of embeddedness. *American Journal of Sociology* 91(3): 481-510.
- Granovetter, M. (1992). *Problems of explanation in economic sociology. Networks and Organizations*. N. Nohria and R. G. Eccles. Boston, Massachusetts: Harvard Business School Press: 25-56.
- Gray, B. (1985). Conditions facilitating interorganizational collaboration. *Human Relations* 38(10): 911-950.
- Gray, B. (1989). *Collaborating. Finding common ground for multiparty problems*. San Francisco, London: Jossey-Bass.
- Gray, B. (1996). *Cross sectional partners: collaborative alliances among business, government and communities. Creating Collaborative Advantage*. C. Huxham. London, Thousand Oaks, New Delhi: Sage: 57-79.
- Gray, B. and D. J. Wood (1991). Collaborative alliances: Moving from practice to theory. *Journal of Applied Behavioral Science* 27(1): 3-22.
- Green, J. (1998). Evidence and policy in accident alliances. Final study report for NHSE North Thames Organisation and Management Group. London, London School of Hygiene and Tropical Medicine.
- Green, J. and F. Delaney (1994). Beyond the bike-sheds. *Health Service Journal* 104(5406): 23.
- Greener, I. (2004). Health service organization in the UK: a political economy approach. *Public Administration* 82(3): 657-76.
- Greenshore Health Authority (1999). Greenshore Health Improvement Programme 1999-2000. Greenshore, Greenshore Health Authority.

- Greenwood, J. and D. Wilson (1989). *Departments and Departmentalism. Public Administration in Britain Today*. London: Unwin Hyman: 21-40.
- Gregory, S., R. Crossley, et al. (1998). Transforming local services. Partnership in action. York Publishing Services, The Joseph Rowntree Foundation.
- Gulati, R. (1999). Where do interorganizational networks come from? *American Journal of Sociology* 104(5): 1439-93.
- Gulland, A. (2003). NHS staff cheat to hit government targets, MPs say. *British Medical Journal* 327(58): 179.
- Hall, R. H. (1984). *Notes of the analysis and measurement of IOR. Interorganizational relations: implications for community development*. C. L. Mulford. New York, N.Y: Human Sciences Press. IV: 191-194.
- Hall, R. H. (1996). *Organizations. Structures, Processes, and Outcomes*. London: Prentice Hall.
- Halpert, B. P. (1982). *Antecedents. Interorganizational coordination. Theory, research and implementation*. D. L. Rogers, Whetten D. A. Ames: Iowa State University Press: 54-72.
- Halverson, P. K., G. P. Mays, et al. (1997). Not-so-strange bedfellows: models of interaction between managed care plans and public health agencies. *The Milbank Quarterly* 75(1): 113-38.
- Ham, C. (1998). Financing the NHS. *British Medical Journal* 316: 212.
- Hambleton, R., S. Essex, et al. (1996). The collaborative council: a study of inter-agency working in practice, LGC Communications in association with the Joseph Rowntree Foundation.
- Hamer, L. (2000). National Review and Analysis of Health Improvement Programmes 1999-2000 (report). London, Health Development Agency.
- Hammersley, M. (1992). *So what are case studies? What's wrong with ethnography? Methodological explorations*. London and New York: Routledge: 183-197.
- Hammersley, M. and P. Atkinson (1995). *Ethnography Principles in practice*. London: Routledge.
- Hansard (2000). *Health Action Zones*, Westminster Hall, London: Hansard.
- Haralambos, M. and M. Holborn (1990a). *Organizations and Bureaucracy. Sociology. Themes and perspectives*. London: Collins Education: 405-52.
- Haralambos, M. and M. Holborn (1990b). *Methodology. Sociology. Themes and perspectives*. London: Collins Education: 698-764.

- Hardy, B., A. Turrel, et al. (1992). *Innovations in Community Care Management: Minimising Vulnerability*. Aldershot: Avebury.
- Hardy, B., G. Wistow, et al. (1990). Policy networks and the implications of community care policy for people with mental handicap. *Journal of Social Policy* 19: 141-168.
- Hardy, C. (1999). Swimming with Sharks: Managing Multi-sector Collaboration in the Canadian HIV/AIDS Domain. Melbourne, Department of Management, University of Melbourne: 1-16.
- Hardy, C. and N. Phillips (1998). Strategies of Engagement: Lessons from the Critical Examination of Collaboration and Conflict in an Inter-organizational Domain. *Organization Science* 9(2): 217-30.
- Harrison, L. and P. Tether (1987). The co-ordination of UK policy on alcohol and tobacco: The significance of organisational networks. *Policy and Politics* 15(2): 77-90.
- Harrison, S. (2001). *Policy analysis. Studying the organisation and delivery of health services. Research methods*. N. Fulop, P. Allen, A. Clarke and N. Black. London and New York: Routledge: 90-106.
- Hasenfeld, Y. (1992). *Theoretical Approaches to Human Service Organizations. Human Services as Complex Organizations*. Y. Hasenfeld. Newbury Park, London, New Delhi: Sage: 24-44.
- Hatch, M. J. (1997a). *Organization Theory. Modern, Symbolic and Postmodern Perspectives*. Oxford, New York: Oxford University Press.
- Hatch, M. J. (1997b). *Control and Ideology in Organizations. Organization Theory. Modern, Symbolic and Postmodern Perspectives*. Oxford, New York: Oxford University Press: 327-349.
- Health Act (1999). *Health Act 1999. Chapter 8*.
- Health and Social Care Act (2001). *Health and Social Care Act 2001. Chapter 15*.
- Helling, A. (1998). Employer-sponsored and self-sponsored participation in collaborative visioning. Theory, evidence and implications. *Journal of Applied Behavioral Science* 34(2): 222-40.
- Higgins, R., C. Oldman, et al. (1994). Working together: lessons for collaboration between health and social services. *Health & Social Care in the Community* 2(5): 269-77.
- Himmelman, A. T. (1996). *On the theory and practice of transformational collaboration: from social service to social justice. Creating Collaborative Advantage*. C. Huxham. London, Thousand Oaks, New Delhi: Sage: 19-44.

- Hoggett, P., Ed. (1997). *New modes of control in the public service*. The Policy Process. London: Prentice Hall, Harvester Wheatsheaf.
- Hoggett, P. (2003). Overcoming the desire for misunderstanding through dialogue. *Local Government Studies* 29(3): 119-127.
- Huberman, A. M. and M. B. Miles (1998). *Data Management and Analysis Methods. Collecting and Interpreting Qualitative Materials*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage: 179-210.
- Hudson, B. (1987). Collaboration in social welfare. A framework for analysis. *Policy and Politics* 15: 175-82.
- Hudson, B. (1997). *Housing, health and community care: the inter-agency dimensions. Health care UK 1996/97: the King's Fund review of health policy*: King's Fund.
- Hudson, B. (1997). *Michael Lipsky and street level bureaucracy. A neglected perspective. The Policy Process*. M. Hill. London: Prentice Hall, Harvester Wheatsheaf: 393-403.
- Hudson, B. (2002). Interprofessionality in health and social care: the Achilles' heel of partnership? *Journal of Interprofessional Care* 16(1): 7-17.
- Hudson, B. (2003). Governance and integrated care: understanding and developing networks at local level, Health Services Management Centre, University of Birmingham.
- Huxham, C. (1996). *Creating Collaborative Advantage. Creating Collaborative Advantage*. C. Huxham: Sage.
- Huxham, C. (1996). *Group decision support. Creating Collaborative Advantage*. C. Huxham: Sage: 141-151.
- Huxham, C. and S. Vangen (1996). Working together: key themes in the management of relationships between public and non-profit organisations. *International Journal of Public Sector Management* 9(7): 5-17.
- Huxham, C. and S. Vangen (2000a). Ambiguity, complexity and dynamics in the membership of collaboration. *Human Relations* 53(6): 771-806.
- Huxham, C. and S. Vangen (2000b). Leadership in the shaping and implementation of collaboration agendas: how things happen in a (not quite) joined-up world. *Academy of Management Journal* 43(6): 1159-75.
- Jackson, P. M. and L. Stainsby (2000). Managing Public Sector Networked Organizations. *Public Money and Management*(January-March): 11-16.
- Jackson, T. (2003). Review. Now let's have evidence based politics. *British Medical Journal* 327(58).

- Jan-Erik Lane (2000). *Concepts of Bureaucracy. The Public Sector. Concepts, Models and Approaches*. London: Sage: 49-71.
- John, P. (1998). *Group and Network Approaches. Analysing Public Policy*. London and New York: Pinter: 66-91.
- Johnston, R. and P. Lawrence (1991). *Beyond vertical integration - the rise of the value-adding partnership. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage: 194-202.
- Jones, G. and J. Stewart, Eds. (2004). *Partnership problems. October 10th 2003. Local Government - Past, Present and Future: A Celebration of the 25 Year Writing Partnership of George Jones and John Stewart*. Birmingham: Institute of Local Government Studies.
- Jones, N., P. Thomas, et al. (2004). Collaborating for mental health: a process evaluation. *Public Administration* 82(1): 109-121.
- Jones, S. (1985). *Depth interviewing. Applied Qualitative Research*. R. Walker. Aldershot: Gower: 45-55.
- Judge, K. (2000). Testing evaluation to the limits: the case of English Health Action Zones. *Journal of Health Services Research and Policy* 5(1).
- Judge, K., M. Barnes, et al. (1999). The National Evaluation of Health Action Zones. Health Action Zones: Learning to make a difference. A report submitted to the Department of Health. Glasgow, University of Glasgow.
- Kaufman, S. R. (1994). *In-depth interviewing. Qualitative interviewing in aging research*. Jaber F. Gubrium and Andrea Sankar. Thousand Oaks, London, New Delhi: Sage: 123-136.
- Keen, J. and T. Packwood (1995). Case study evaluation. *British Medical Journal* 311: 444-6.
- Kickert, W., E.-H. Klijn, et al. (1997a). *Introduction: A Management Perspective on Policy Networks. Managing complex networks. Strategies for the public sector*. W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 1-11.
- Kickert, W., E.-H. Klijn, et al. (1997b). *Managing Networks in the Public Sector: Findings and Reflections. Managing complex networks. Strategies for the public sector*. W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 166-191.

- Kickert, W. and J. F. M. Koppenjan (1997). *Public Management and Network Management: An Overview. Managing complex networks. Strategies for the public sector.* W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 35-61.
- Kirkpatrick, I. (1999). Market, Bureaucracy and Public Management. The Worst of Both Worlds? Public Services without Markets or Bureaucracy. *Public Money and Management*(October-December): 7-14.
- Klein, R. (2001). *The New Politics of the National Health Service.* Harlow, England: Prentice Hall.
- Klijn, E.-H. (1997). *Part I. Policy Networks and Network Management: a State of the Art. Policy Networks: An Overview. Managing complex networks. Strategies for the public sector.* W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 62-78.
- Klijn, E.-H. and G. R. Teisman (1997). *Part II. Networks Dynamics and Management. Strategies and Games in Networks. Managing complex networks. Strategies for the public sector.* W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 98-118.
- Kmietowicz, Z. (2003). Short term measures to meet NHS targets cannot be sustained. *British Medical Journal* 326) 1229.
- Knight, T., J. Smith, et al. (2001). Developing sustainable collaboration: learning from theory and practice. *Primary Health Care Research and Development* 2(139-48).
- Korczynski, M. (2000). The political economy of trust. *Journal of Management Science* 0022-2380(January): 1-21.
- Langley, A. (1999). Strategies for theorizing from process data. *Academy of Management Review* 24(4): 691-710.
- Lannin, H. (2002). Health Action Zones: evaluation to shape experience. Thesis submitted 2002. London, LSE.
- Lasker, R. D., E. S. Weiss, et al. (2001). Partnership synergy: a practical framework for studying and strengthening the collaborative advantage. *Milbank Quarterly* 79(2): 179-206.
- Laverack, G. and R. Labonte (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning* 15(3): 255-262.
- Lawrence, T. B., N. Phillips, et al. (1999). Watching Whale Watching. Exploring the Discursive Foundations of Collaborative Relationships. *Journal of Applied Behavioral Science* 35(4): 479-502.

- Lawson, L., M. Mackenzie, et al. (2002). Health Action Zones: Integrated Case Studies - preliminary findings from fieldwork in Spring 2001. The National Evaluation of Health Action Zones. Glasgow, University of Glasgow.
- Le Grand, J. (1997). Knights, Knaves or Pawns? Human Behaviour and Social Policy. *Journal of Social Policy* 26: 149-169.
- Le Grand, J. (1998). The third way begins with CORA - community, opportunity, responsibility and accountability. *New Statesman*: 26-27.
- Leach, R. and J. Percy-Smith (2001a). *Above and Below Local Government: Multi-level Governance. Local governance in Britain*. Hampshire and New York: Palgrave.
- Leach, R. and J. Percy-Smith (2001b). *Local governance in Britain*. Hampshire and New York: Palgrave.
- Leathard, A. (1994). *Inter-professional developments in Britain. An overview*. London and New York: Routledge.
- LGA (2000). Partnerships with health. A survey of local authorities. London, Local Government Association.
- Lichtenstein, R., J. A. Alexander, et al. (1997). Embedded Intergroup Relations in Interdisciplinary Teams. Effects of Perceptions of Level of Team Integration. *Journal of Applied Behavioral Science* 33(4): 413-34.
- Lipsey, R. G. and K. A. Chrystal (1995). *An Introduction to Positive Economics*. London: Weidenfield and Nicholson.
- Local Government Act (2000). *Local Government Act 2000. Chapter 22*.
- Logsdon, J. M. (1991). Interests and interdependence in the formation of social problem-solving collaborations. *Journal of Applied Behavioral Science* 27(1): 23-37.
- Lomi, A. and M. Prevezer (1996). *Networks for innovation in biotechnology. Knowledge, Technology and Innovative Organisations*. J. Butler and A. Piccaluga. Milan: Guerini e Associati: 363-378.
- Lowndes, V. and C. Skelcher (1998). The dynamics of multi-organizational partnerships: an analysis of changing modes of governance. *Public Administration* 76(Summer): 313-334.
- Lowndes, V. and H. Sullivan (2004). Like a horse and carriage or a fish on a bicycle: How well do local partnerships and public participation go together? *Local Government Studies* 30(1): 51-73.
- Loxley, A. (1997). *Collaboration in health and welfare: working with difference*. London, Bristol, Pennsylvania: Jessica Kingsley.

- Lukes, S. (1974). *Power: A Radical View*. London: MacMillan.
- Machado, N. and T. Burns (1988). Complex social organisations: multiple organising modes, structural incongruence, and mechanisms of integration. *Public Administration* 76(Summer): 355-386.
- Macpherson, W., T. Cook, et al. (1999). The Stephen Lawrence Inquiry. Report of an inquiry by Sir William Macpherson of Cluny. Advised by Tom Cook, the Right Reverend Dr John Sentamu, Dr Richard Stone. Presented to Parliament by the Secretary of State for the Home Department by Command of Her Majesty. London, The Stationery Office. Cm 4262-I.
- Manning, P. K. and B. Cullum-Swan (1998). *Narrative, content and semiotic analysis. Collecting and Interpreting Qualitative Materials*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage: 246-273.
- Mannion, R. and P. Smith (1997). *Trust and Reputation in Community Health Care: theory and evidence. Changes in health care. Reflections on the NHS internal market*. Paul Anand and Alistair McGuire: Macmillan Business: 141-61.
- Marcus, L. J., B. C. Dorn, et al. (1995). *Renegotiating Health Care*. San Francisco: Jossey-Bass.
- Marks, L. and D. J. Hunter (2000). Health Improvement Programmes: a review of research. A report commissioned by the Department of Health R&D division, Nuffield Institute for Health, University of Leeds: 41.
- Markwell, S. (1998). *Exploration of conflict theory as it relates to healthy alliances. Alliances in health promotion: theory and practice*. A. Scriven. Basingstoke and London: Macmillan.
- Marsh, D. (1998). *The development of the policy network approach. Comparing policy networks*. D. Marsh. Buckingham: OUP.
- Martin, P. Y. and B. A. Turner (1986). Grounded Theory and Organizational Research. *Journal of Applied Behavioral Science* 22(2): 141-157.
- Matka, E., M. Barnes, et al. (2002). Health Action Zones: 'Creating Alliances to Achieve Change'. *Policy Studies* 23(2): 97-106.
- Mattessich, P. W. and B. R. Monsey (1992). *Collaboration: what makes it work. A review of research literature on factors influencing successful collaboration*. St Paul, Minnesota: Amherst H. Wilder Foundation.
- May, T. (1997). *Social research. Issues, methods and process*. Buckingham, Philadelphia: Open University Press.

- Mays, N. and C. Pope (1995). Observational methods in health care settings. *British Medical Journal* 311: 182-184.
- McCabe, A. L., V., Skelcher, C. (1997). *Partnerships and networks. An evaluation and development manual*. York: YPS for the Joseph Rowntree Foundation.
- McKenny, J. L., M. H. Zack, et al. (1992). *Complementary Communication Media: A Comparison of Electronic Mail and Face-To-Face Communication in a Programming Team. Networks and Organizations*. N. Nohria and R. G. Eccles. Boston, Massachusetts: Harvard Business School Press: 262-287.
- Means, R., M. Brenton, et al. (1997). *Making partnerships work in community care: a guide for practitioners in housing, health and social services*. Bristol: University of Bristol, Policy Press.
- Medd, W. (2000). *Complexity and partnership*. Breaking Barriers: a one day conference exploring different aspects of partnership working, University of Brighton: Institute for Public Health Research and Policy. University of Salford, Manchester.
- Meyer, J. (2001). *Action research. Studying the organisation and delivery of health services. Research methods*. N. Fulop, P. Allen, A. Clarke and N. Black. London and New York: Routledge: 172-87.
- Miles, M. B. and A. M. Huberman (1994). *Qualitative data analysis. An expanded source book*. Thousand Oaks, London, New Delhi: Sage.
- Miller, G. (1997). *Contextualising texts: studying organizational texts. Context and Method in Qualitative Research*. G. Miller and R. Dingwall. London, Thousand Oaks, New Delhi: Sage: 77-91.
- Mitchell, J. (1991). *Introduction. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University & Sage.
- Molnar, J. J. (1984). *Qualitative and quantitative methods in interorganizational research. Interorganizational relations: implications for community development*. C. L. Mulford. New York, N.Y: Human Sciences Press. IV: 199-203.
- Morgan, G. (1986). *Introduction. Images of Organization*. Beverly Hills: Sage: 11-17.
- Morgan, G. (1990a). *Management and Bureaucracy in Organizations. Organizations in Society*. Basingstoke and London: Macmillan: 63-93.
- Morgan, G. (1990b). *Organizations and Environments. Organizations in Society*. Basingstoke and London: Macmillan: 155-94.

- Mulford, C. and D. Rogers (1982). *Definitions and models. Interorganizational coordination. Theory, research and implementation*. D. L. Rogers, Whetten D. A. Ames: Iowa State University Press.
- Mulford, C. L. (1984). *Interorganizational relations: implications for community development*. New York, N.Y: Human Sciences Press.
- Mulrow, C. and A. Coxman (eds) (1997). Cochrane Collaboration Handbook [Update September 1997] In: The Cochrane Library [database and CDROM] The Cochrane Collaboration. Oxford: Update; 1994 Issue 4.
- Nash, W. (1993). *Jargon: Its uses and abuses*: Basil Blackwell.
- Nathan, M. L. and I. I. Mitroff (1991). The use of Negotiated Order Theory as a tool for the analysis and development of an interorganizational field. *Journal of Applied Behavioral Science* 27(2): 163-180.
- National Audit Office (2001). Tackling Obesity in England. Report by the Comptroller and Auditor General, National Audit Office: The Stationery Office. London.
- National Heart Forum (1999). All Party Parliamentary Group on Primary Care and Public Health Inquiry into Health Improvement Programmes, December 1999. Written evidence by the National Heart Forum. London, National Heart Forum.
- Newell, S. and J. Swan (2000). Trust and inter-organizational networking. *Human Relations* 53(10): 1287-1328.
- NHS Executive (1999a). Development and Performance Framework. Version 2. London, Department of Health.
- NHS Executive (1999b). The NHS Performance Assessment Framework. London, Department of Health.
- NHS Executive, The Institute of Health Services Management, et al. (1998). *In the public interest. Developing a strategy for public participation in the NHS*: NHS Executive, The Institute of Health Services Management, The NHS confederation.
- NHS Executive London Regional Office (1999). London's Health Improvement Programmes. Findings from the first phase of development 1998/99. Final Report, NHS Executive London Regional Office.
- Nocon, A. (1994). *Collaboration in Community Care in the 1990s*. Sunderland: Business Education Publishers.
- Nocon, A., N. Small, et al. (1993). Made in heaven? *Health Service Journal* 163(5381): 24-26.

- Nohria, N. and R. G. Eccles (1992a). *Networks and Organizations. Networks and Organizations*. N. Nohria and R. G. Eccles. Boston, Massachusetts: Harvard Business School Press.
- Nohria, N. and R. G. Eccles (1992b). *Face-To-Face: Making Network Organizations Work. Networks and Organizations*. N. Nohria and R. G. Eccles. Boston, Massachusetts: Harvard Business School Press: 288-308.
- NSPCC and the Children's Society and the National Children's Bureau (1999). Improving Children's Health: a survey of 1999-2000 health improvement programmes, NSCPP.
- Nuffield, Institute, et al. (1998). Inter-agency collaboration. *Update*: 1-6.
- Oakley, P. and H. M. Kahssay (1999). *Community involvement in health development: an overview. Community involvement in health development: a review of the concept and practice*. H. M. Kahssay and P. Oakley. Geneva: World Health Organization.
- Oliver, C. (1990). Determinants of Interorganizational Relationships: Integration and Future Directions. *Academy of Management Review* 15(2): 241-265.
- Oliver, C. (1991). Network relations and loss of organizational autonomy. *Human Relations* 44(9): 943-61.
- ONS and (Office for National Statistics (formerly Office of Population Censuses and Surveys) (1991). Key population and vital statistics: local and health authority areas. Series VS PP1, 1991.
- Ottewill, R., A. Wall, et al. (1996). The 'right to be clean': an analysis of the Kirklees home bathing service. *Health and Social Care in the Community* 4(6): 377-380.
- Ouchi, W. E. (1991). *Markets, bureaucracies and clans. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage: 246-255.
- Øvretveit, J. (1993). *Coordinating community care. Multidisciplinary teams and care management*. Buckingham, Philadelphia: Open University Press.
- Parsons, W. (1995). *Public policy. An introduction to the Theory and Practice of Policy Analysis*. Cheltenham, Lyme: Edward Elgar.
- Pawson, R. D. and N. Tilley (1997). *Realistic Evaluation*. London: Sage.
- Peckham, S., P. Taylor, et al. (2004). Bringing People In. Participative and collaborative approaches to support local public health action, UKPHA.
- Pettigrew, A., E. Ferlie, et al. (1992a). *Shaping Strategic Change*. London: Sage.
- Pettigrew, A., E. Ferlie, et al. (1992b). *Understanding the process of change. Shaping Strategic Change*. London: Sage: 5-30.

- Pettigrew, A. M. (1985). *The Awakening Giant*. Oxford: Blackwell.
- Pettigrew, A. M. (1997). What is processual analysis? *Scandinavian Journal of Management* 13(4): 337-348.
- Pfeffer, J. (1997). *Five Models of Behavior. New Directions for Organizational Theory. Problems and Prospects*. New York, Oxford: Oxford University Press: 42-80.
- Pfeffer, J. and G. R. Salancik (1978). *The external control of organizations: a resource dependency perspective*. New York: Harper & Row.
- Phillips, N., T. B. Lawrence, et al. (2000). Inter-organizational collaboration and the dynamic of institutional fields. *Journal of Management Studies* 37(1): 23-43.
- Pickin, C., J. Popay, et al. (2002). Developing a model to enhance the capacity of statutory organisations to engage with lay communities. *Journal of Health Service Research Policy* 7(1): 34-42.
- Pierre, J. and B. G. Peters (2000). *Governance, Politics and the State*. Hampshire: Macmillan.
- Popay, J. and G. Williams (1998). Partnership in health: beyond the rhetoric. *Journal of Epidemiology & Community Health* 52(7): 410-411.
- Powell, M. (1992). *Healthy alliances. Report to the Second Health Gain Standing Conference*: Office for Public Management.
- Powell, M. and G. Moon (2001). Health Action Zones: the 'third way' of a new area-based policy. *Health and Social Care in the Community* 9(1): 43-50.
- Powell, W. W. (1991). *Neither market nor hierarchy. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage: 265-76.
- Power, M. (1997). *The audit society: rituals of verification*: Oxford University Press.
- Poxton, R. (1999). *Partnerships in Primary and Social Care*. London, King's Fund.
- Pratt, J., D. Plamping, et al. (1998). *Urban Health Partnership. Partnership: fit for purpose? Whole Systems Thinking working paper series*. London: King's Fund.
- Ranade, W. and B. Hudson (2003). Conceptual issues in inter-agency collaboration. *Local Government Studies* 29(3): 32-50.
- Rathwell, T. (1992). Pursuing Health for All in Britain - an assessment. *Social Science & Medicine* 34(2): 169-182.
- Rawson, D. (1994). *Models of inter-professional work. Likely theories and possibilities. Going inter-professional: working together for health and welfare*. A. Leathard. London and New York: Routledge.

- Read, M. D. (1992). *Policy Networks and Issue Networks. The politics of smoking. Policy Networks in British Government*. D. Marsh and R. A. W. Rhodes. Oxford: Clarendon Press: 124-148.
- Reed, M. I. (1992). *Analytical frameworks. The Sociology of Organizations. Themes, Perspectives and Prospects*. New York, London, Toronto, Sydney, Singapore: Harvester Wheatsheaf: 72-129.
- Reitan, T. C. (1998). Theories of Interorganizational relations in the human services. *Social Service Review* 72(3): 285-309.
- Rhodes, R. A. W. (1988a). *Policy network and sub-central government. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage.
- Rhodes, R. A. W. (1988b). *Beyond Westminster and Whitehall. The Sub-Central governments of Britain*. London, Sydney, Wellington: Unwin Hyman.
- Rhodes, R. A. W. (2000a). The governance narrative: key findings and lessons from the ESRC's Whitehall programme. *Public Administration* 78(2): 345-363.
- Rhodes, R. A. W. (2000b). New Labour's Civil Service: Summing-up Joining-up. *The Political Quarterly* 71(2): 151-166.
- Rhodes, R. A. W. and D. Marsh (1992). *Policy Networks in British Politics: A critique of existing approaches. Policy Networks in British Government*. D. Marsh and R. A. W. Rhodes. Oxford: Clarendon Press: 1-26.
- Richards, T. J. and L. Richards (1998a). NUD*IST 4. Box 171, La Trobe University Post Office, Viv 3083, Australia, Qualitative solutions and research.
- Richards, T. J. and L. Richards (1998b). *Using computers in qualitative research. Collecting and Interpreting Qualitative Materials*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage: 211-245.
- Roberts, N. C. and R. T. Bradley (1991). Stakeholder Collaboration and Innovation: A Study of Public Policy Initiation at the State Level. *Journal of Applied Behavioral Science* 27(2): 209-227.
- Roberts, V., H. Russell, et al. (1995). Public/Private/Voluntary partnerships in Local Government. Liverpool John Moores University, European Institute for Urban Affairs.
- Robinson, J. and R. Poxton (1998). *Health and social care partnerships. Implementing the White Paper: pitfalls & opportunities. A King's Fund analysis of Labour's plans for the NHS*. M. Benzeval and R. Klein. London: King's Fund.
- Robinson, R. (2002). Who's got the master card? *Health Service Journal* 112(5824): 22-24.

- Roe, B., Guinness L., Rafferty A., Gillies P. (1997). Evidence on the effectiveness of alliances for health promotion: a systematic literature search and qualitative annotated bibliography, Centre for Policy in Nursing Research, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine and the Health Education Authority on behalf of the World Health Organization.
- Rogers, D. L. (1982). *Reflections and synthesis: new directions. Interorganizational coordination. Theory, research and implementation*. D. L. Rogers, Whetten D. A. Ames: Iowa State University Press: 177-185.
- Rogers, D. L., Whetten D. A. (1982). *Interorganizational coordination. Theory, research and implementation*. Ames: Iowa State University Press.
- Rosenhead, J. (2001). *Operational research. Studying the organisation and delivery of health services. Research methods*. N. Fulop, P. Allen, A. Clarke and N. Black. London and New York: Routledge: 154-171.
- Rosenhead, J. and J. Mingers (2001a). *A New Paradigm of Analysis. Rational Analysis for a Problematic World Revisited. Problem Structuring Methods for Complexity, Uncertainty and Conflict*. J. Rosenhead and J. Mingers. Chichester: John Wiley: 1-20.
- Rosenhead, J. and J. Mingers (2001b). *A New Paradigm of Analysis*. Chichester.
- Roussos, S. T. and S. B. Fawcett (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health* 21: 369-402.
- Rushmer, R. and G. Pallis (2002). Inter-professional working: The wisdom of integrated working and the disaster of blurred boundaries. *Public Money and Management*(October-December): 59-66.
- Ryan, T. and C. Bamber (2002). Pricing participation: A survey of organisational payment practices to users and carers for expenses and time given in service development and delivery. Working Briefing paper - Version 1, North West Mental Health Development Centre, Institute for Applied Health and Social Policy (IAHSP), King's College.
- Saad, M., K. Rowe, et al. (1999). *Developing and Sustaining Effective Partnerships Through a High Level of Trust*. Public and Private partnerships: Furthering development, Cork, Ireland: European Regional Studies Unit, Faculty of Languages and European Studies. University of the West of England, Bristol, UK.
- Sanderson, I. (1990). Effective inter-sectoral collaboration: the theoretical issues, Policy Research Institute. Leeds Metropolitan University.
- Schaap, L. and M. J. W. van Twist (1997). *Part II. Networks Dynamics and Management. The dynamics of closedness in networks. Managing complex networks. Strategies for the*

public sector. W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 62-78.

- Scharpf, F. W. (1978). *Interorganizational Policy Studies: Issues, Concepts and Perspectives*. *Interorganizational Policy Making. Limits to coordination and central control*. K. Hanf and F. W. Scharpf. London and Beverly Hills: Sage. 1: 345-70.
- Schofield, J. (1997). Working together: differing perspectives and persuasions amongst health and social care authorities. *Health Services Management Research* 10(3).
- Schuman, S. P. (1996). *The role of facilitation in collaborative groups. Creating Collaborative Advantage*. C. Huxham. London, Thousand Oaks, New Delhi: Sage: 126-40.
- Scott, C. and W. Thurston (1997). A framework for the development of community health agency partnerships. *Canadian Journal of Public Health, Ontario* 88(6).
- Scott, J. (1991). *Social Network Analysis*. London, Thousand Oaks, New Delhi: Sage.
- Scriven, A. (1995). Healthy alliances between health promotion and education: the results of a national audit. *Health Education Journal*(54): 176-85.
- Shepherd, M. (2000). *Public Involvement in Health Authority Decision Making. A National Survey*. Partnership, power and participation. UK PHA annual conference, Harrogate.
- Shifrin, T. (2002). United Bristol chief quits before latest star-ratings are revealed. *Health Service Journal* 112(5813): 4-5.
- Silverman, D. (1993). *Interpreting qualitative data. Methods for analysing talk, text and interaction*. Thousand Oaks, London, New Delhi: Sage.
- Silverman, D. (1998). The quality of qualitative health research: the open-ended interview and its alternatives. *Social Sciences in Health* 4(2): 104-118.
- Skelcher, C., Ed. (2004). *A Commentary on 'Partnership problems'*. Local Government - Past, Present and Future: A Celebration of the 25 Year Writing Partnership of George Jones and John Stewart. Birmingham: Institute of Local Government Studies.
- Smith, M. J. (1997). *Policy Networks. The Policy Process*. M. Hill. London: Prentice Hall, Harvester Wheatsheaf: 76-86.
- Snape, S. and P. Taylor (2003). Partnerships between health and local government: An introduction. *Local Government Studies* 29(3): 1-16.
- Snow, C. C., R. E. Miles, et al. (1993). *Managing 21st Century Network Organizations. Managing Change*. C. Mabey and B. Mayon-White. London: The Open University, Paul Chapman Publishing: 20-34.

- Social Exclusion Unit (1998). *Bringing Britain Together: a national strategy for neighbourhood renewal*. London: The Stationery Office.
- Social Exclusion Unit (2000). *National strategy for neighbourhood renewal: a framework for consultation*. London, Cabinet Office.
- Stake, R. E. (2000). *Case Studies. Handbook of Qualitative Research*. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, London, New Delhi: Sage: 436-454.
- Strauss, A. L., L. Schatzman, et al. (1963). *The Hospital and its Negotiated Order. The Hospital in Modern Society*. Freidson E. London New York: Collier-Macmillan, Free Press: 147-169.
- Sullivan, H., M. Barnes, et al. (2002). Building collaborative capacity through 'Theories of Change': early lessons from the evaluation of the Health Action Zones in England. *Evaluation* 8(2): 205-226.
- Sullivan, H., M. Barnes, et al. (2004). Power, participation and the practice of accountability. *Local Governance* 30(1): 42-51.
- Sullivan, H., K. Judge, et al. (2004). 'In the eye of the beholder': perceptions of local impact in English Health Action Zones. *Social Science & Medicine* 59: 1603-1612.
- Taket, A. (1999). *Creating effective partnerships for public health. Public Health Challenges for the 21st Century*: Health Education Authority.
- Taket, A. and L. White (2000a). *Introduction to the multiagency setting. Partnership and Participation*. Chicester: John Wiley: 3-17.
- Taket, A. and L. White (2000b). *Partnership and Participation*. Chicester: John Wiley.
- Taylor, M. (1997). *The best of both worlds: the voluntary sector and local government*. York, Joseph Rowntree Foundation.
- Termeer, C. J. A. M. and J. F. M. Koppenjan (1997). *Part II. Networks Dynamics and Management. Managing perceptions in networks. Managing complex networks. Strategies for the public sector*. W. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, New Delhi: Sage: 79-97.
- Thompson, G. (1991a). *Markets, Hierarchies and Networks. The co-ordination of social life*. London, Thousand Oaks, New Delhi: The Open University and Sage.
- Thompson, G. (1991b). *Comparison between models. Introduction. Markets, Hierarchies and Networks. The co-ordination of social life*. G. Thompson, J. Francis, R. Levačić and J. Mitchell. London, Thousand Oaks, New Delhi: The Open University and Sage.
- Thompson, P. and D. McHugh (1995). *Organisational design: beyond bureaucracy*. Hampshire, London: Macmillan Business.

- Thompson, P. R. and S. Stachenko (1994). Building and mobilizing partnerships for health: a national strategy. *Health Promotion International* 9(3): 211-215.
- Trist, E. (1983). Referent Organizations and the Development of Inter-organisational Domains. *Human Relations* 36(3): 269-284.
- Turcotte, M.-F. and J. Pasquero (2001). The Paradox of Multistakeholder Collaborative Roundtables. *The Journal of Applied Behavioral Science* 37(4): 447-464.
- Underdown, A. and C. Sexty (2000). Getting the hump with HImPs. *Health Service Journal* 110(5689): 22-24.
- University of Warwick, Liverpool John Moores University, et al. (2004a). Evaluation of Local Strategic Partnerships. Performance Management: A briefing note for LSPs by LSPs, Office of the Deputy Prime Minister.
- University of Warwick, Liverpool John Moores University, et al. (2004b). Evaluation of Local Strategic Partnerships. Community engagement: A briefing note for LSPs by LSPs, Office of the Deputy Prime Minister.
- Unwin, J. and P. Westland (2000). Health Action Zones. The engagement of the voluntary and community sector, The Baring Foundation.
- Vangen, S. and C. Huxham (2003). Nurturing Collaborative Relations. Building Trust in Interorganizational Collaboration. *The Journal of Applied Behavioral Science* 39(1): 5-31.
- Wanless, D., A. Charlesworth, et al. (2002). Securing Our Future Health: Taking a Long-Term View. Final Report. London, HM Treasury.
- Wanless, D., N. Jones, et al. (2004). Securing Good Health for the Whole Population. Final Report. London, HM Treasury.
- Watson, B. (1999). Living up to Expectations - Can the Public Sector Deliver? *Public Money and Management*(July-September): 5-7.
- Webb, A. (1991). Coordination: a problem in public sector management. *Policy and Politics, Bristol* 19(4): 229-241.
- Weber, M. (1964). *The Types of Authority and Imperative Co-ordination. The Theory of Social and Economic Organization*. T. Parsons. New York: The Free Press: 324-41.
- Webster, C. (2002). *The National Health Service. A political history*: Oxford University Press.
- Westley, F. and H. Vredenburg (1997). Interorganizational collaboration and the preservation of global biodiversity. *Organization Science* 8(4): 381-403.
- Wilcox, D. (1994). *The Guide to Effective Participation*. York: Joseph Rowntree Trust.

- Williams, P. (2002). The competent boundary spanner. *Public Administration* 80(1): 103-124.
- Williamson, O. E. (1975). *Markets and Hierarchies*. New York: Free Press.
- Wilson, A. and K. Charlton (1997). Making partnerships work. A practical guide for the public, private, voluntary and community sectors. York Publishing Services, The Joseph Rowntree Foundation.
- Winer, M. and K. Ray (1994). *Collaboration handbook: creating, sustaining, and enjoying the journey*. Saint Paul, Minnesota: Amherst H. Wilder Foundation.
- Wistow, G. (1992). *The Health Service Policy Community: Maintaining a Closed Relationship. Policy Networks in British Government*. D. Marsh and R. A. W. Rhodes. Oxford: Clarendon Press: 51-74.
- Wood, D. J. and B. Gray (1991). Towards a comprehensive theory of collaboration. *Journal of Applied Behavioral Science* 27(2): 139-162.
- Wright, K. (2001). The National Health Service Reform and Health Care Professions Bill. Bill 47 of 2001-2002. Research Paper 01/95. London, House of Commons Library.
- Yin, R. K. (1994). *Case Study Research. Design and methods*. Thousand Oaks, London, New Delhi: Sage.
- Zaheer, A., B. McEvily, et al. (1998). Does Trust Matter? Exploring the Effects of Interorganization and Interpersonal Trust on Performance. *Organization Science* 9(2): 141-159.

Appendices A - O

Appendix A

Summary of interpretive and contextual facilitators of inter-organisational co-ordination

Facilitators	
Interpretive	Contextual
Perceived need	Actual needs/benefits
Rewards outweigh costs	Scarce resources
Perceived benefits	Organisation/environmental norms of innovation and co-ordination
Positive attitudes	Standardisation
Consensus between administrators and staff	Decentralisation
Maintenance of organisational and paradigm identity	Professionalism
Maintenance of organisational/leader-staff prestige/power/domains	Occupational diversity
Cosmopolitan ethos	Broad range of services
Group-centred approach to problems	Differentiated outputs
Rewards for group-centred approach/environmental outreach	Leadership qualities
Accessibility to other organisations	Standardised referrals
Positive evaluations of other organisation/staff	Informal contacts/exchange of information and resources
Similar resources/goals/needs	Geographic proximity
Common commitment	Boundary permeability/roles
Common definitions/ideologies/interest/approaches	Complementary organisational/personnel roles
Agreement in domains/value of co-ordination	Similarity of structures/supply capabilities/needs/services
Perceived partial interdependence	Voluntary association membership
Good historical relations	Volatility in the political-economic system

Source (Halpert 1982) pp.63

Summary of interpretive and contextual inhibitors of inter-organisational co-ordination

Inhibitors	
Interpretive	Contextual
Vested interests	Costs outweigh benefits
Perceived threat/competition	Bureaucratisation
Perceived loss of organisational and programme identity/strategic positions	Centralisation
Perceived loss of organisational lead-staff prestige/authority/domains	Professionalisation
Lower service effectiveness	Specialisation
Client alienation	Inadequate internal communication/ tolerance
Inability to serve new clientele	Little or no boundary permeability/roles
Differing organisational/leader-professional socialisation	Infrequent/inadequate external communication
Differing leadership approaches/authority	Structural differences
Disparities in staff training	Difference in priorities/resources/ functions/goals/operation/tasks
Inter- and intra-professional differences	Unilateral exchange rates
Different priorities/ideologies/ outlooks/goals	Fragmentation of the environment- federal/state/local levels of government
Lack of common language	Turnover of policy personnel
Internal norms against environmental outreach	Inadequately trained governmental personnel
Negative evaluations of other organisations	Government intrusion and disruption
Imperfect knowledge on environment	
Poor historical relations/image formation	
Perceived sanctions by network members	

Source (Halpert 1982) pp.69

Appendix B

Literature search, search strategy and issues

This appendix describes the search strategy used for the literature review in this thesis. The aim of the review was to identify, draw together and distil the theoretical literature and empirical evidence on health partnership. Its primary focus was on health or health care partnerships in the UK public sector although, where appropriate, it drew on theoretical and empirical literature on other types of partnership, often based in another academic disciplines. A detailed account of the process is described below but first I discuss the use of Systematic Reviews.

Systematic Reviews

In Public Health and Medicine there is a growing emphasis on identifying and summarising research evidence in a standardised and systematic way. One approach – the Systematic Review – has become widely recognised, spawning a number of tools and organisations to further its development and assemble databases of secondary evidence (i.e. the Cochrane database). Derived from the Evidence Based Medicine/Practice movement, the Systematic Review seeks to promote a more rigorous, methodological approach to critically appraising and summarising the literature. A key characteristic of this approach is the grading of evidence according to the methodological design of the study under scrutiny, with experimental studies (particularly Randomised Controlled Trials) accorded greater weight. As such the approach is firmly rooted in the positivist paradigm.

However, the use of the Systematic Review methodology to evaluate the evidence on health partnership was not considered appropriate for this study. Roe (1997) has noted a number of methodological difficulties in adopting such an approach to review evidence on alliances or partnerships for health promotion. These include: the lack of international standardisation of terminology relating to partnership (see Section 1.2.1 in Chapter 1), limiting the ability to search electronic databases systematically; the poor flexibility of some search facilities as well as incompatibility between different databases (Roe 1997); and the large number of publications that are not registered on electronic databases, whether contemporary or those published before 1980 (Mulrow and Coxman (eds) 1997).

Aside from these practical limitations, a number of issues stem from the fact that this study is not just interested in the outcome but the motivations of actors and the process/management of partnership. Studies evaluating process, for example, are likely to use survey or case study research strategies or even developmental strategies (such as Action/Operational Research) in preference to experimental ones (Meyer 2001; Rosenhead 2001). Case studies in particular are more about describing and explaining the process of partnership than quantifying it. They are often formative, using qualitative data collection methods. However, unlike experimental methods and survey methods, the criteria for assessing the quality of these studies is highly contested (Altheide and Johnson 1998), let alone the criteria for combining the findings from different qualitative studies. Although frameworks for assessing the quality of studies have been developed (Gerring 2001), ultimately the preferred criteria of the researcher is likely to depend on his or her theoretical perspective and the focus of his/her research.

The inappropriateness of the Systematic Review does not mean that a comprehensive and systematic search strategy should not be conducted, or that explicit criteria for judging studies should not be employed. On the contrary, there is a need for indicators of quality as long as they are not applied in a hierarchical and hegemonic fashion (Ferlie 2001). One such criterion is explicitness of method, of which the literature review is an integral part. The approach I have taken is outlined below.

Comprehensive literature review

A comprehensive literature review was carried out to review research relating to partnership and health strategy. The purpose of the review was to identify studies that had evaluated health and health and social partnership in the UK as well as methodological approaches to evaluation of health partnerships. This included the literature on factors influencing partnerships, the management or development of partnership and normative frameworks for developing partnership. In addition, the review sought to identify more general theoretical perspectives on partnership working and policy formation and implementation that have been used in the field of health and social welfare. The review was therefore multi-disciplinary in nature.

Computerised Bibliographic Searches

Five databases were comprehensively searched to identify articles, studies and reports for inclusion in the literature review: *Medline* (1966-2005), *Health Star* (1988-2005), *HMIC* (*Health Management Information Consortium*), *PUBMED* (1981-2005) and *BIDS IBSS* (*international bibliography of the social sciences*) (1981-2005).

Given that the terminology relating to partnership is not standardised, a broad search strategy was used to ensure that a comprehensive range of material relating to partnership or the process of partnership was identified. A four-stage strategy was employed.

1. A search for articles that encompass the following health themes was performed:

Health Strategy/Health Policy/Health of the Nation/Our Healthier Nation/Primary Care Groups/Health Improvement Programmes/HIMP/HIMP/Health Action Zones/HAZ/ Healthy Cities/ Health For All/Social Care/Local Strategic Partnership/LSP

2. A search was performed using the term 'partnership' and other related terms, used in meaningful permutations, shown below:

Inter/multi/trans

and

Agency/Sectoral/Disciplinary/Professional/Occupation/Alliances

and

Partnership/Collaboration/Co-ordination/Co-operation/Cooperation/Integration/Teamwork/Joint working

3. A search for articles relating to the theoretical and practical aspects of assessing and evaluating partnerships was carried out using the following terms:

4. Finally, since each stage identified a large amount of material, I decided to focus the search down into a manageable number of articles by combining the results of each stage of the search in the following ways: Stages 1 and 2, Stages 2 and 3, Stages 1 and 3 and Stages 1 and 2 and 3. The results of these combinations were checked individually for their relevance to the subject matter.

For practical reasons non-English language articles identified were excluded.

Additional 'grey' material was also sought by searching the University of London library catalogue systems, as well as health management libraries such as at the King's Fund, using the search terms outlined above. The internet was also used to identify material on health partnership, particularly unpublished articles or reviews by key authors or material from government department websites.

Other relevant papers/studies/articles were identified through the BIDS citation database and through 'snowballing' references in articles, reports or books and hand-searching key journals.

The literature search was repeated periodically in recognition of the number of studies on partnership (as a consequence of the government's agenda and reforms) in progress throughout the research.

All literature was rated and prioritised in terms of its 'relevance' and 'methodological rigour'.

Appendix C

Table C1. Summary of the findings of studies evaluating the factors that influence UK health partnerships (HImP and HAZ)

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
Sullivan (2004)	UK	HAZ	N=8 In-depth case study focused on 34 'successful' interventions Used Theories of Change framework, focusing on outcomes (impact and success) as perceived by local stakeholders	1. Shared goals - Links between HAZ strategy and projects not clear, partly as a result of the instability of HAZ strategies	2. Skills & competencies	3. Approaches to partnership - Judgement of HAZ success mostly on process issues (not outcome) but limited by national changes and uncertainty resulting in a loss of interest by champions, feeling of isolation	4. Quality of relationships - Some evidence of voluntary sector influence on decision-making but it was difficult to identify ways in which communities were influential at the strategic level	5. Structure(s)	6. Environment - Turbulence and uncertainty destabilised HAZ strategies. In particular the change in Secretary of State led to a shift in priorities; the development of NSFs interrupted the implementation of strategies as priorities changed to capitalise on national priorities. Uncertainty about HAZ as a priority – and therefore future funding – truncated certain projects (biggest influence) - Strong emphasis on targets and 'quick wins' limited local success and

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(Cole 2003)	England	HAZ	N=1 Case study, using semi-structured interviews (72). Focus on learning and on projects (37) reflecting on Realistic Evaluation and Theories of Change as an approach to evaluation	- Strong users/carers involvement in decision-making resulted in bringing in new perspectives - Fostering a joint understanding of each others' problems contributed to the development of trust	- Practitioner's lack of knowledge and understanding of the two frameworks weakened their will to evaluate - Expertise/skills of key personnel were associated with successful projects. Appointed experts could help with evaluation	- Evaluation had low priority with senior managers because it was perceived as either irrelevant or a threat - Evaluation was too onerous for small partners, given the size of grants - Projects contributed to partnership working: HAZ money acts as a catalyst for new projects or long-standing issues	- Trust was fostered by partners developing projects together, reaching at level of open criticism - Cultural convergence – overcoming linguistic and cultural differences, was associated with successful projects - Senior management support for projects was helpful in developing project, but could be undermined by individuals moving on	- Evaluation and learning were weakened by the changing composition of the evaluation board and lack of dedicated staff to evaluate initiatives - The government's emphasis and requirement to evaluate partnership and its work created resentment and undermined local efforts to create an evaluative culture - Local projects which reflected the national priorities and agendas i.e. the NSF's, were more likely to succeed	therefore dilute local impact by limiting room for manoeuvre
Matka (2002)	England	HAZ	N= 5 Part of the national evaluation, using	- A key element to project implementation was the early	- Successful project implementation required	- Change requires organisational development. This requires	- Lack of infrastructure, resources and access to insider	- Different scale and circumstance of each HAZ area i.e. history and	- Speed of change in the health economy constrained the

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			<p>Realistic Evaluation and Theories of Change as the evaluative framework.</p> <p>Focus on partnership and voluntary sector involvement</p>	<p>1. Shared goals</p> <p>establishment of a coherent vision across all levels of the partnership</p> <ul style="list-style-type: none"> - The relevance of the task to core business and how it is sold is important to involving partners 	<p>2. Skills & competencies</p> <p>capacity building within profession and statutory sectors</p>	<p>3. Approaches to partnership</p> <p>operational people to be involved in the process</p> <ul style="list-style-type: none"> - Need to understand power differential and practices across traditional boundaries 	<p>4. Quality of relationships</p> <p>information undermined the voluntary sectors capacity to be involved and influence the agenda i.e. be an equal partner</p>	<p>5. Structure(s)</p> <p>nature of local communities was influential, resulting in simple and complex structures</p>	<p>6. Environment</p> <p>ability and willingness of partner agencies to engage with HA, particularly the voluntary sector which needed lengthy support to increase its capacity and therefore be involved as equals. This requires extra funding and development, otherwise their engagement will lose out to quick wins</p> <ul style="list-style-type: none"> - Changing organisational structures and policies impacted on capacity to work together. Rapid change does not facilitate 'joining up' and delays the time taken to develop partnership - Short term

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Exworthy (2002)	England	HImPs	N=3 Case studies using 45 in-depth, semi-structured interviews and documentation. Focuses on the implementation of the health inequalities agenda within HImP partnerships. Uses Kingdon's model of 'policy streams'	- Health inequalities not recognised as a sufficiently pressing local <i>problem</i> , especially outside public health departments - Partners see it as a 'health/NHS problem'	- Local policy entrepreneurs were important in coupling streams and developing policy on health inequalities but lack of a corporate approach meant that progress was vulnerable to changes in post		- Ownership of local health inequalities initiative by policy entrepreneurs was undermined by the centre's strong promotion of other priorities in partner organisations		funding makes it difficult to sustain change resulting from partnership - Additional money provided a breathing space for organisations - The structure and changing emphasis of the performance management system and the nature of targets and indicators employed, hampered implementation of the agenda at the local level. For example, health inequalities targets were 'soft' and long term and therefore hard to measure compared with 'hard' hospital process targets. This made it difficult to monitor as well as

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Barnes (2001)	England	HAZ	N=8 Part of the national evaluation, using Realistic Evaluation and Theories of Change as the evaluative framework. Used questionnaires, interviews and documentary material. Focused on partnership element and the voluntary sector's involvement	- Four types of strategy identified: i. Consolidation – taking stock and removing obstacles ii. Mainstreaming – crosscutting health issues securing better understanding of roles iii. Emergent – new systems to work on health and health inequalities iv. Innovations – to test out new projects challenging conventional approaches to delivery and decision-making. The type of strategy was influenced by partnerships' differing views on purpose	- The degree of satisfaction with community involvement influenced strategy	- Not a strategic view of capacity building	- Capacity to develop strategy affected by the legitimacy of stakeholders and power relations - Way in which people work together formally and informally important	- Geographical tensions were an important influence such as LA boundaries, community identity and allegiance and political culture and relations - Population change and diversity create significant challenges to addressing local needs	exacerbated by a change requirement to plan for 3 year plans down from 7 - Pressure to achieve early wins - Plethora of government policy initiatives - Constraints imposed by centralised performance management frameworks. Not considered locally as a mechanism for learning - Uncertainty and timescales introduced as consequence of changing policy context - Insufficient resources prevents capacity building

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(LGA 2000)	England	HImP/HAZ	N=295 Cross-section survey of partnership in local authorities. Results weighted to adjust for non-responders (28%). Questionnaire contained questions on factors facilitating partnership	- Partners recognising that they had similar aims and priorities was helpful (28%) - Recognising the benefit from sharing (10-20%) - Lack of understanding of each other's role weakened partnership (19%)	- Presence of champions or personalities was helpful (10-20%)	- Willingness of key personnel and senior management to give it importance (10-20%) - Political support (10-20%) - Fear of financial risks and cultural resistance to sharing resources undermine efforts at partnership (35%) - Partners using the medical model hindered partnership (19%)	- Close working relations without competitiveness facilitates partnership (<20%) - Understanding culture and processes of organisations (<10%) - Poor personal relationships create boundaries (16%)	- Creating PCGs helpful in improving joint working and involvement of GPs (<20%) - Lack of coterminosity (12%) - Developing joint planning strategies and links to the community plan (<10%) - Unsynchronised budgets (35%) and timescales (13%) - Different accountability structures (8%)	- Current climate emphasising partnership and statutory requirement or on partnership working was helpful (43%) - History of joint working (10-20%) - Incentives/ additional funding helpful (10-20%) but differential growth, lack of LA funding can hinder efforts (35%) - Lack of human resource - Tension between national (NHS) and local LA priorities (10%)
Unwin (2000)	UK	HAZ	N=3 (all first wave HAZ sites) Interviews with key stakeholders (number not specified) conducted in two phases (1998 and early 2000)		- Low wages and quality of senior officers, coupled with low organisational back up, and lack of training, and an expectation of	- Recognise that the process of timing and resource consuming and the benefits may be some time off	- Pre-occupation with internal re-organisation of NHS undermined government's emphasis on voluntary sector inclusion - Voluntary sector	- Voluntary sector capacity requires considerable development if it is to play an effective role - Lack of fit of voluntary sector's governance	- Massive policy turbulence in voluntary and statutory sectors and lack of capacity to cope with changes - Compacts welcome but

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			The study focuses on engagement of the voluntary sector		multi-tasking, undermined the voluntary sector's ability to engage		felt vulnerable because of funding arrangements and vested interests. This coupled with a felt loss of autonomy, resulted in a power imbalance with the statutory sector	structures with partnership/ statutory agencies - Complexity of partnership governance and structures - 'Flat' organisations have difficulty in engaging in strategic and operational tiers of partnership	impact not yet clear
Arora (2000) Arora (1999)	England	HIMP	N=5 Rapid appraisal using semi-structured questionnaires. The focus was on what worked well and problem that had arisen	- Health improvement a broad agenda with different meaning for different stakeholders. Lack of a shared vision lead to confusion about role and responsibilities		- Take time and effort, increase by the large number of stakeholder, with little tangible outcome - Difficult to maintain long-term interest in strategic processes with nebulous outcomes. Quick wins may be important. Having measurable, meaningful indicators could be helpful in maintaining	- Different cultures and ways of working were barriers to partnership - GPs not likely to take a strategic population approach	- HIMP too big and involves too many people so difficult to make it a priority - Lack of organisational development limited PCGs ability to consult - With most resources tied up in acute services, difficult to develop health improving activities	- Policy overload and the pace of change - Lack of or ring-fencing of resource was perceived as a barrier to partnership and outcomes, particularly in an atmosphere of resource scarcity - HIMP not re-directing core resource to HIMPs but PM could help - Short-time scale limited the extent

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						progress. Agreeing indicators could be an aid in itself			of public consultation, falling short of the ideal set out in guidance. Need to take a co-ordination approach to avoid consultation fatigue
(Judge, Barnes et al. 1999)	England	HAZ	N=11 (all first wave HAZ sites) Part of the national evaluation, using Realistic Evaluation and Theories of Change as the evaluative framework. But no theories of partnership specifically used	- Lack of clarity from centre of the vision for HAZ. Need to establishing a clear vision and shared understanding locally	- Need to improve communication: share information systems and with outside world	Need to build organisational capacity: PCGs and general lack of managerial capacity - Existing infrastructure, lack of resources and capacity limited engagement of community - Language excludes voluntary sector	Some defensiveness and protectionism and thinking of what's in it for them, commitment to own organisation, networks of linkages important - Tension over representativity of the voluntary sector	- Coterminosity helpful - History of poor relations - Lack of resource to tackle agenda - Size and speed of the reform agenda, time frame and different priorities - Promised freedoms not materialised - Pressure for early wins	Very top down (not bottom up) partnerships - Lack of resource to tackle agenda - Size and speed of the reform agenda, time frame and different priorities - Promised freedoms not materialised - Pressure for early wins
Carruthers (1999)	England	HIMP	N=7. Case study, qualitative (1998/99), rapid appraisal using semi-structured interviews, documents. The	- Shared agenda more likely where the leadership was inclusive, particularly evident in HAZ	- As process leaders the HA had to develop local priorities in order to keep local stakeholders on board for future	-HIMP concept was welcomed in sites, receptiveness and interest in HIMP -Voluntary sector needed longer to consult than the timetable permitted.	- (HA) delivery had to be balanced with inclusive conduct to avoid domination - Where there was greater sharing of power and responsibility there	- Confusion between role and function of HAZ and HIMP - partnerships, leading to further confusion and waste. Time	- The pace of change and tight operation deadlines imposed on NHS restricted in-depth involvement of potential

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				1. Shared goals	2. Skills & competencies	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
			study focused on the promotion and barriers to partnership, using CHD policy to track progress		<p>rounds</p> <ul style="list-style-type: none"> - DPH was driver and champion but some saw long-term leadership role with LA 	<p>It was restricted by its capacity (finances or people) to respond to the timetable</p> <ul style="list-style-type: none"> - Need to ensure medical model does not prevail; otherwise LA and other partners might withdraw - 3/7 cases included the SaFF and JIP in the HImP. Where strands of work were not integrated, there were tensions in the senior management of the HA - Matching local and national priorities sends a positive signal about partners meeting their own goals, especially if resources available - Introducing a framework for implementation and 	<p>was greater commitment from the 'top managers' and more of a blind eye to boundaries (people, processes, budgets etc). Continuity of leadership was helpful.</p> <ul style="list-style-type: none"> - Early process conduct set the tone for future relations, particularly a no blame climate, but this needs to be institutionalised into organisations 	<p>wasted trying to integrate the two into core business.</p> <ul style="list-style-type: none"> - The presence of a HAZ helped develop joint working in the HImP (i.e. understand a shared agenda, with clear priorities etc) - Having clear mechanisms and structures provides positive signals to stakeholders, with Board able to take a strategic view - PCGs and GPs need to be more engaged if co-creation is to be achieved - Pace of change does not take into consideration different local planning and resource allocation 	<p>stakeholders, including NHS Trusts and voluntary sector</p> <ul style="list-style-type: none"> - CEOs recognised the need to balance short term focus on health service with longer term health improvement concerns - Ring-fencing reduced flexibility to deliver wide health agenda, as targeted at NHS issues. <p>Earmarking also restricted PCGs' aspirations</p>

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NHS Executive London Regional Office (1999)	England	HImPs	N=16. Rapid appraisal using discussion groups and telephone interviews and documents (1999). Focus on progress and difficulties	<ul style="list-style-type: none">- The vision developed had to be balanced by the management of expectations- It was difficult to keep some stakeholders on board if their interests were not included in the local priorities- The broad programme tried to cover too much. There was tension between the 'top down' priorities and 'bottom up', especially with so many national priorities		<p>performance delivery helps convey importance of issue</p> <ul style="list-style-type: none">- Holding stakeholder events and conferences was a good way of developing networks, improving communication and agreeing priorities, but need a strategic approach for on-going dialogue with the voluntary sector- There's a need to focus on tangible results to keep participants interested- Lack of clarity on accountability arrangements with regard to progress against targets was a cause for concern	<ul style="list-style-type: none">- Lack of familiarity with the public health perspective was considered a barrier to some Trusts	timetables	<ul style="list-style-type: none">- Flexible HImP guidance, combined with variations in local history and levels of partnership working have led to different priorities, focus and levels of progress. Some joint working beyond the area of Social Services- Tensions arose over the geographical boundaries and whether they should be for the PCG, LA or HA- Other existing partnership initiatives helped create a positive atmosphere for partnership and provide a stimulus for LAs to look at <ul style="list-style-type: none">- Government requirement to produce HImP strategy provided legitimacy- Process generated enthusiasm- Time pressures on lead agencies made maintaining active involvement difficult, especially for the voluntary sector. It also made it difficult to integrate local planning cycles and funding streams, particularly the SaFF and JIP- The multiplicity of initiatives created confusion and misunderstanding amongst stakeholders- Financial support

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								<p>the needs of their community. Building of existing structures and priorities was helpful</p> <ul style="list-style-type: none"> - Some duplication of effort with existing service plans 	<p>would help partnership working</p> <ul style="list-style-type: none"> - Financial pressure meant developing PCGs and organisational change was very demanding and there were concerns for delivering the HImP programme - New duty of partnership thought beneficial

Table C2. Summary of the findings of studies evaluating the factors that influence UK health partnerships (HOTN, HC, HFA and other health partnerships)

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
Peckham (2004)	England	Primary care partnerships (including HAZ areas)		<p>1. Shared goals</p> <ul style="list-style-type: none"> - PCTs need to understand and recognise the agenda of other organisations to work more effectively 	<p>2. Skills & competencies</p> <ul style="list-style-type: none"> - The presence of a senior PCT individual engaging in partnership elevated its status and made actions more effective - Boundary spanners are crucial to linking the community, public health agenda and partnerships. Some of these individuals were appointed; others were working informally. They are catalysts for thinking strategically and outside the box, for developing new projects - They need to be flexible and reflexive and be able to network 	<p>3. Approaches to partnership</p> <ul style="list-style-type: none"> - Involvement of lay members often as an after thought. This undermined their role and left them unclear about their contribution. Some staff saw their contribution as a challenge - As partnership seen as a 'must do' activity processes were often ignored. - Involvement often seen as a project rather than thinking about how and why they could contribute - Public health and peripheral activity for PCTs, with little evidence in their CPD or induction roles. 	<p>4. Quality of relationships</p> <ul style="list-style-type: none"> - Primary care practitioners mainly perceive public health in their own practice as opportunist health promotion with individuals or running clinic based services - Public involvement requires substantial change in professional attitudes and organisational structures. It also requires time and the building of trusting relations 	<p>5. Structure(s)</p> <ul style="list-style-type: none"> - PCTs lack resource to fully engage in participation - A history of partnership working in the area made developing relationships easier - Existence of a strong voluntary sector can act as positive influence 	<p>6. Environment</p> <ul style="list-style-type: none"> - Organisational change made staff very internally focused - As new organisations PCTs have not had enough time to consolidate themselves - PCTs driven very much by central government agenda and did not view the detail of partnership but seen as a 'must do' activity

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				1. Shared goals	2. Skills & competencies with people from different backgrounds, generally informally -Organisations need to understand the importance of boundary spanners and to develop these roles	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
Pickin (2002)	England	Health partnerships (not stated by probably HImPs/ HAZs)	N=3 Case study using semi-structured interviews with stakeholders and a deliberative workshop with key 'informants'. Focused on developing a model to enhance lay community engagement in strategic health partnership	- Allowing the voluntary sector to define needs but not to contribute to solutions creates frustration and anger, whilst over simplistic solutions from statutory organisations are confounded by lack of understanding of the sector's history and culture	- Leadership required to overcome the risk-adverse culture towards involving the voluntary sector - The statutory sector needs to develop skills in conflict management and techniques for engaging communities. This requires a change in culture	- Lack of a strategic approach to working with communities means the voluntary sector has not received statutory support. Past inequalities in partnership are maintained and lack of understanding and responsiveness by statutory organisations is maintained	- Patronising attitudes towards the voluntary sector, compounded by professional service culture and ethos (i.e. the biomedical model rather than a social model of health) and different cultures (i.e. on innovation and risk taking and accountability) influenced the statutory sector's ability to see the benefit of involving		- Dynamics of the national political system: a very crowded implementation agenda caused policy overload resulting in reactive rather than considered responses

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Knight (2001)	England	Health Promotion/ Joint Commissioning partnerships	N=2 Case study/action research, drawing data from facilitation, observation and evaluation of partnerships. Retrospective analysis (five years) which applied a framework to consider different forms of value (legitimacy, purpose, security, conduct, adaptability and productivity) argued to be key to sustaining partnership	- Developing a common sense of purpose from the start amongst all players and a structure which fits with existing local institutional frameworks is important, with management capacity and resources providing 'teeth' to partnership. These factors help aid legitimacy, and lead to greater security and long-term productivity	- Legitimacy can be undermined by not having senior enough staff present to commit resources	- For partnership to be sustainable it needs to be valued. Value comes from being productive, efficient, secure, legitimate and adaptable (consequential value) when compared against other organisational arrangements. Value can also be embedded in partnership's purpose, capacity to produce benefit, institutional fit and conduct (constitutive value)	the voluntary sector in partnership, limiting involvement - Early consideration of conduct is important i.e. how to involve the voluntary sector, to avoid it becoming an issue - Conduct of partnership combined with a lack of capacity, undermining security of relations	- Organisational arrangement needs to consider sustainability of partnership as their value is seldom produced immediately - Structural solutions alone are not sufficient to deliver and sustain productive relationships - Structures need to be adaptable to changing environment	- Government/ national agencies can provide external legitimacy i.e. when it fits with the institutional context - Early securing of resources can bolster capacity and couple with common purpose. This was a significant factor in sustainability
Evans (2000)	England	HIPP programme	N=5 (each a different model of partnership). Case study over two years using primarily	- Developing a strong sense of purpose (shared understanding and agreement of a vision) takes	- Leadership by local champions for integrated working was crucial in positioning the	- More successful at developing processes than delivering service changes on the ground or to	- Different cultures can strain commitment - Good relations required mutual	- Commitment can be strained by different structure and processes	- Commitment can be strained by different priorities - National and local policy

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			qualitative data collections, mainly semi-structured interviews. Used an evaluative framework based on Realistic Evaluation and Pettigrew's (1992) model of receptive and non-receptive contexts for change	considerable time and effort - joint assessment of community needs is important for ownership	project on the strategic agenda and project management. It also helped ensure there were sufficient resources - Team building was important in building capacity for partnership	demonstrate health outcomes in 2 years - The degree of participation in and accountability for projects related to shared ownership and the quality of relations. - A participative model of partnership creates tension between hierarchical health care structures and processes	understanding and respect of professional background	- Different accountabilities were a source of tension - Formal arrangements were not enough (eg. steering group) for genuine accountability	turbulence affected the ability to position the project on the strategic agenda and to get additional resources - The degree of readiness and experience of integrated joint planning influenced the extent and pace of progress in sites
DoH (1998a)	England	Health policy – national HOTN	Qualitative. Case study (N=16) 133 interviews and document	- Acknowledge different organisational cultures - Targets should be evidenced-based and local	- Coterminosity - Staff skills	- Involve all stakeholders, including the public	- Shared ownership	- Accountability through monitor and evaluation - Organisational 'turbulence' - Senior support	- Historical traditions and culture - Local political environment - Resources and need for incentives
Green (1998)	England	Health Alliance - accidents	Qualitative. Case study (N=5) using interviews, NOP and documents	- Flexible organisational culture where staff are encouraged to value others, - Mutual respect	- Skilled chairperson with sufficient authority	- Sense of alliance belonging to all participants	- Mutual respect as a result of secondment	- Heavy work load reduces time and energy - Involvement of senior management on strategic groups	- Resource constraints

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				1. Shared goals	2. Skills & competencies	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
				and networking				and appropriate front line staff to operationalise policy - Funded co-ordinator beneficial - Organisational uncertainty and staff turnover led to loss of knowledge and pessimism	
De Leeuw (1998)	UK/ Europe	Healthy Cities Project	Qualitative case studies (N=10, 1 UK). 303 semi-structured interviews drawing on three theories by Gray, Gusfield and Kingdom	- Identified three types of models: health, city and vision. Health sees opportunities for restructuring health (care) of people: City sees health as metaphor for urban development; - Vision refers to popular health to keep the city in readiness for new, future developments - Policies of	- The presence of social entrepreneurs (tacticians) capable of analysing Kingdoms 3 streams directed towards activities with the highest potential gain. Three levels of entrepreneurship are identified, institutional over individual being most effective. Social entrepreneurs are	- Establishing a need for a healthy city rather than doing it for reasons of legitimacy enhances development - Recognising collaboration as a power game and focusing on domains where limited number of stakeholders and resources available to get quick results - Credibility enhanced by WHO backing important - Producing a HC		- Intra-apparatus collaboration determines the set-up and feasibility of joint work with other sector. Cities with a broader range of focus of priority control (i.e. technical, bureaucratic or political) are more effective in achieving truly healthy public policies. This is not decision-making - Determining the	- Resources (hard paid staff and budgets to run initiatives) are not crucial to success of HCP even where there were local resource cut-backs, although more was better than less. But they are important

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				1. Shared goals selecting non-competitiveness and quick win projects in the beginning are a crucial predictor for success	2. Skills & competencies constrained by the locus of priority control; when evenly spread it's easier for them to operate	3. Approaches to partnership Plan was a useful process and very important component of sustainability of the NCP. Commitment to health important. Ownership depends on objectives, locus of control, creative use of resources etc - Projectism important but can hinder development of policy if lesson not learnt. Need to see HCP beyond projects as innovative and building block of policy for sustainability - Evaluation itself can make a difference	4. Quality of relationships	5. Structure(s) set-up and feasibility of joint work. Political control and monitoring over HCP inhibits efficient inter-sectoral negotiation whereas a technical locus of priority control brings in other sectors	6. Environment
Cornish (1997)	UK	Health policy –regional HOTN	Qualitative. Case study (N=14) interviews, focus groups, survey (non random) and documents	- Different organisational cultures, agendas, priorities and notions of health	- Organisational awareness about other partners	- Integrate health strategy into work of whole organisation		- Partnership's work realistic and relevant - Organisational timetables can be problematic	- Difference, perceived or otherwise, in political orientation - Lack of resources

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				were barriers. - Good working relationships top and bottom of organisation				<ul style="list-style-type: none"> - Product champions at senior level. Right people at right level - Pace of organisational change hampered stable relationships 	
Costongs (1997)	UK	Healthy Cities -Liverpool	Qualitative. Used RAAKS and RAP methodology including semi-structured interviews, PO, and documents	<ul style="list-style-type: none"> - Recognising mutual dependence - Communication is restrained by world view of organisations. This process requires time 	<ul style="list-style-type: none"> - Capacity to mobilise, and organise support in network - Skilful chairing of conflict in meeting. - Good leadership. Training recommended 	<ul style="list-style-type: none"> - Maintaining partnership requires constant re-appraisal, monitoring and on-going evaluation 	<ul style="list-style-type: none"> - Open communication and language important and boost confidence and willingness - Power relations determined by background of partners, commitment of organisation, personality and skills, facilitation skills by chairperson 	<ul style="list-style-type: none"> - Degree of formalisation and its communication can be a source of power conflict. Formalisation is not enough on its own - Organisations' commitment: junior officers do not have sufficient political clout or authority 	
Bloxham (1996)	UK	Healthy alliance in sexual health and education	Qualitative. Case study (N=1) used interviews	<ul style="list-style-type: none"> - Shared aims developed incrementally and based on shared vision, possibly facilitated by 			<ul style="list-style-type: none"> - Good communication: formal and informal. - Ensure agreed priorities, clarity 	<ul style="list-style-type: none"> - Strategic planning at senior level is necessary 	<ul style="list-style-type: none"> - Conflicting government policy of national curriculum and sex education

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				informal training. Conflicts need to be resolved - Need to combine strategic approach with participation of staff			about different boundaries and need to preserve uniqueness of roles - Mutual respect of values and methods of working - Helped by personal networks		
Scriven (1995)	UK		Quantitative and Qualitative. (N=112) 64% used questionnaires, semi-structured interviews and focus group					- Coterminality facilitates partnership but the effect of non-coterminality is not so clear - Joint appointment, especially in contracting organisations important but must be permanent - Changing organisational roles and staff are constraints. - Uncertainty about funding	- Lack of resources - Presence of national policy although this could also be a barrier. Government award schemes encourage alliances
Delaney (1994)	UK	Health For All and Healthy	Qualitative. (N=2) City &	- Shared values and vision.	- Awareness of remit and	- Bottom-up approach involving		- Different channels of	- Reputation and history of

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
				1. Shared goals	2. Skills & competencies	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
		Cities	mixed urban/rural sites. Used unstructured interviews	<ul style="list-style-type: none"> - Important factor helping trust - Competition between professional networks/groups hindered - Different views of health 	<ul style="list-style-type: none"> responsibilities - Range of skills important: boundary spanning, networking skills, communications and strategic thinking 	community created sense of ownership		<ul style="list-style-type: none"> accountability and communications can result in conflicts in planning and time scales - Coterminality can be essential but double-edged. - Senior commitment a significant factor - Need for group c.f. individual ownership so staff turnover does not affect partnership 	<ul style="list-style-type: none"> organisations and previous collaborations - Political control or clout and party politics can be influential - Economic and resource constraints are barrier i.e. lack of time
Davies (1993)	UK	Health Alliances - London	Qualitative. Case study (N=3) using observation and in-depth interviews	<ul style="list-style-type: none"> Need clarity about what they offer and what will help achieve consensus of aims, objectives and roles 	<ul style="list-style-type: none"> - Personality, communication, commitment and enthusiasm, flexibility - Specific posts or support teams should be encouraged 		<ul style="list-style-type: none"> - Need for mutual respect, trust and sharing of power - Power relationships were barrier. Equally, sharing of power is important 	<ul style="list-style-type: none"> - Encourage the use of formal structures that are jointly developed and owned. - Communication channels need to be established in all sectors involved in liaison and collaboration - Managerial and organisational commitment important at both strategic and 	<ul style="list-style-type: none"> - Within health promotion relations were defined by power - Lack of political understanding. Professional and organisational jealousy - Lack of secure and stable funding important. Agencies must be clear about what resources they can offer

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
				1. Shared goals	2. Skills & competencies	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
Nocon (1993)	UK	Healthy alliances		<ul style="list-style-type: none"> - All parties must have something to gain. Requires compatible objectives, joint agenda setting, strategy formulation and implementation 		<ul style="list-style-type: none"> - Health needs to be defined by community to ensure participation - Ideas of front line staff are not taken seriously 	<ul style="list-style-type: none"> - Health Authority control of agenda may undermine others' influence 	operational levels <ul style="list-style-type: none"> - Tight planning structures and deadlines (management pressures) can rule out discussion with other agencies - Sending junior officers undermines commitment of organisations, and the contribution to a general strategic plan - Impact greatest where a co-ordinator is appointed - Uncertainty about future - Impact of purchaser-provider split 	<ul style="list-style-type: none"> - Political differences lead to mistrust and conflict - Commitment of organisational resources as an incentive to joint work - Single Regeneration Budget bids can be a stimulus
Powell (1992)	UK	Mix of health alliances (inc. HFA/HCs, single issue)	Qualitative. Case study (N=8) interviews	<ul style="list-style-type: none"> - Shared goals important but be clear about own values 	<ul style="list-style-type: none"> - Range of skills, attributes and attitudes need to be developed: building. 	<ul style="list-style-type: none"> - Need for legitimacy, momentum and motivation: use as many mechanisms 	<ul style="list-style-type: none"> - Shared vision - Common agenda & agreed priorities - Mutual respect and creating trust 	<ul style="list-style-type: none"> - Structures determine relations, resources and community 	<ul style="list-style-type: none"> - History important in shaping future - Each partner must contribute resources and

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
				1. Shared goals	2. Skills & competencies	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
				- Broad goals build on common notion of health. Targets must relate to goals	communication, marketing, organisation & planning, negotiation, managing, training, administration and fundraising	as possible - Learn about each other through doing, and success and failure.		involvement - Need for networking outside formal structures - Locating level of power and having top level commitment - Creation of organisation, team or post to facilitate functioning	allow their flexible use. This reflects commitment, ownership and balance of power.
Rathwell (1992)	UK	HFA	N=63 Quantitative survey. Response rate was 70%		- Poor awareness of HFA	- Lack ownership		- Lack of commitment	- Lack of adequate resources (money, time and staff) - Lack of political will and conflicting policy. Promotion of agenda by interest groups

Table C3. Summary of the findings of studies evaluating the factors that influence UK health and social care partnerships

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context	
Poxton (1999)	England	Joint commissioning, primary care	N=5. Qualitative Case study during 1996-98. Data collection not specified. Focus is on the achievement and difficulties in establishing joint commissioning arrangements	<ul style="list-style-type: none">- Primary care practitioners do not understand difference between joint working and joint commissioning, inhibiting progress.- Leadership has a role to play in providing vision- When collaboration is only seen as a technical process of co-ordinating planning and budgetary cycles, progress is limited- Partnerships need to hold shared vision of desired outcomes and how the problem could be tackled	<ul style="list-style-type: none">- Joint commissioning mainly relies on the inclination of particular practitioners i.e. where there are pilot schemes- Insufficient focus on outcomes of collaboration, and too much on process- Effective relations require strong, sensitive leadership to deal with the mix of powerful political, managerial and professional interests- Leaders require skills to forge new working relationships	<ul style="list-style-type: none">- Where users/carers have participated their involvement has been constructive and illuminating- Problems aligning/pooling locality budgets have impeded attempts to improve services, not helped by different planning cycles/regimes- Joining of budgets was small scale and not mainstream- Process of joint decision-making not clear	<ul style="list-style-type: none">- The perceived fragile nature of relations was a source of reluctance to users/carers who have played little part in collaboration- Cultural issues around hierarchical constraints and different ways of working were significant barriers to joint commissioning, especially where disrespect was shown	<ul style="list-style-type: none">- Most joint working where social workers/care managers are co-located with GPs, improving communication and access to services- Joint commissioning failed when based around GP practices, and efforts to take a practice population approach have failed. There has been greater progress working in locality groups, when activities linked to local strategic priorities and contracts- Weak vertical links/communication between practice, locality and strategic levels caused difficulties in provision within a coherent set of priorities	<ul style="list-style-type: none">- Changes to organisational structures and policies undermined decision-making- Little support from the centre, efforts mainly based on local 'movers and shakers'- incentives might not be useful, rather having joint resources to invest is the key	6. Environment
Nuffield (1998)	UK	Inter-agency collaboration	N=4. Qualitative.	<ul style="list-style-type: none">- Important to have some clarity	<ul style="list-style-type: none">- Accountability to who requires	<ul style="list-style-type: none">- Recognise roles and responsibilities	<ul style="list-style-type: none">- Government guidance must be			

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
				1. Shared goals	2. Skills & competencies	3. Approaches to partnership	4. Quality of relationships	5. Structure(s)	6. Environment
		between health and social services	Cross case study using semi-structured interviews, non participant observation and documentary analysis	about shared aims and objectives whilst recognising the inter-dependence and separateness of organisations		clarification and mechanisms to monitor activity			clear about the ends but allow scope for local latitude in the means to achieve it. - Financial incentives are important especially where special budget created locally
Higgins (1994)	UK	-Inter-agency collaboration between health and social services	N=1, qualitative. Longitudinal case study using interviews (n=46), non participant observation and documents	- Need to clarify aims and objectives. These have to be robust to withstand organisational and individual change - Cultural and professional differences were a barrier to this	- Reassessment of professional roles requires education and training - Issue of confidentiality - Transferable management skills of project manager proved difficult	- Clarify joint management arrangements	- Need to clarify roles and responsibilities.	- Organisational 'turbulence' and staff changes weakened commitment and changed senior management priorities	- Attempts at forming common budgets failed due to local political and organisational factors. These need to be recognised.
Challis (1988)	UK	-National co-ordination and local collaboration between health and local government agencies	- Three interlocking studies, two focused on central government and one at the local level. The latter used	- Policy incongruence and disagreement over fundamental policy stances such as definitions of community care	- Presence of tacticians and committed personalities and their skill in perceiving opportunities and circumnavigating barriers	- Staff in HA and LA accorded different status. SS seen as amateurish and HA high tech/skilled - Political commitment, especially from	- Poor relations between key actors. Professional defensiveness sees co-ordination as peripheral - Political culture and perceptions of NHS as	- People in structures - Organisational arrangements of service capital and production may inhibit new development where they are contracting	

Author	Location	Type	Methodology	Process (cognitive)	Process (management)	Process (management)	Process (social)	Context	Context
			case studies (N=6). Methods employed included in-depth interviews documentary analysis and non-participant observation	1. Shared goals (in and between agencies i.e. SS and education)	2. Skills & competencies	3. Approaches to partnership members, was important	4. Quality of relationships undemocratic - Political ideology could hinder collaboration	5. Structure(s) - Structural complexity and scale and the extent to which it opens up space for tactical activity. This requires central mandate and incentives. Size and scale of organisations participating and their power to attract attention Different time perspective - Different planning cultures: HA centralised and very inflexible and LA more bottom-up. Also fiscal turbulence especially in LA, and different planning cycles.	6. Environment

Appendix D

Synthesis of framework for the development of partnership

The empirical literature consistently identifies four broad process stages in the development of partnership development.

1. **Assessment of initial position:** a necessity to work in partnership should be based on a need. This need may be perceived differently by different partners and needs to be *reframed* in a language that reflects all the partner's culture, interests and values. Not only will it help the formulation of a shared vision for the partnership but serve as an incentive to collective action, helping to overcome historical organisational conflict or independence and bridging the gap to greater interdependence. This will help develop goal consensus. Mapping of resources and organisational structures, responsibilities and arrangements will identify what is needed to meet the vision. An evaluation of how supportive the external environment is towards partnership will help identify potential difficulties with financial and political support.
2. **Creation and consolidation of the partnership:** the structure and operation or approach of the partnership needs to be negotiated and agreed upon by all partners or stakeholders as does the allocation of roles, responsibilities and functions. This may be facilitated by a group leader. Clear lines of communication, in and outside the partnership, need to be agreed to prevent frustration and anger through misunderstanding, as do mechanisms for accountability. This will build up trust and enable information and resources to be exchanged more easily.
3. **Managing the partnership and programme delivery:** Trust will be at its lowest point at this stage and will be indicated by degree of commitment of group members. Communication will continue to be important. Careful attention to use of language, which is understood by all partners despite their differing levels of knowledge and culture, can avoid feelings of separation and frustration amongst partners. Three levels of awareness will be required: what is the response of individuals' desired outcome of partners, how are the dynamics of the group and what is response of individuals in the group to their situation. The process of managing programme implementation requires partners to have skills in strategic and political thinking, verbal and non-verbal communication and networking. These skills can be learned.
4. **Evaluation of partnership:** This is to ensure the partnership is responding to its environment, meeting local needs. Evaluation needs to assess not only the outcome of partnership but also the process of partnership and the costs and benefits involved (tangible and intangible). This is a continuous process which takes place at every stage of development of the partnership and not only at the end. Who is involved in the evaluation will depend on the level of participation of those involved in partnership, but ideally it should include all partners. If the need for partnership has been fulfilled or political or financial support runs out, the partnerships needs to consider whether it should disband, keep going or develop the more successful aspects of the partnership. It should not kept going for its own sake.

Appendix E

Table showing the characteristics of previous programmes to encourage partnership in health and health & social care

Characteristics of partnership model	Epoch				
	2000	1990s	1990/80s	1990/80/70s	1960s
	HImP/HAZ	HOTN	HC/HFA 2000	JCC/JCPTs	
Whole systems	✓	X	X	X	X
Social model of health	✓	X	✓	X	X
Managing networks	✓	X	X	X	X
Exhortation	✓	✓	✓	✓	✓
Partnership as mainstream. More coherent policy	✓	X	X Still a marginal activity	X JCPTs to take strategic approach	X
Relaxation of statutory requirements (JCCs no longer mandatory)	✓	X	X	X	None
Government funding	✓HAZs X HImPs	X	X	✓JF Arrangements for funding care changed, but not to LAs' satisfaction	None
Use of incentives (funding, freedoms and flexibilities)	✓ Performance management	X	X	✓JF introduced	X
Use of sanctions	✓	X	X	X	X
Policy based on altruistic assumptions	✓	✓	✓	✓	✓
Policy based on pessimistic assumptions	✓	X	X	✓ (some)	X
Mandatory local structures	X	X	X Voluntary	✓	X
Cross-governmental structures	✓HAZs ✓PH Minister	✓ (weak)	X	✓ & X (JASP)	X
Lack of clarity over roles and responsibilities (domain consensus)	✓ Guidance clarified	Still unresolved	N/A	X Government failed to resolve differences between NHS and LA on care	X
Strategic partnerships	HImPs	✓	Phase III-IV	JCPTs	X
Voluntary sector involvement	✓	✓	✓	✓JCCs (1983) Remained discretionary for JCPTs	X

Appendix F

Table summarising key demographic indicators in each case study site

Summary Indicators	Dalesville	Greenshire	Metroville	Middleton
Approx. Population size	198,000	668,000	374,000	301,000
No. of local authorities	4	8	2	1
Local authority structure	1CC, 3UC	1CC, 6DC, 1UC	2BC	1UC
NHS trusts	1 AT 1C&M	6 AT 1MT	3 AT 1 C&M	1 AT 1C&M
PCGs	5	7	4	3
CHCs	3	3	1	1
OPCS Area Classification	Rural (mixed urban/ rural)	Rural	Urban	Urban (manufacturing)
Jarman score (rank)	49	42	97	87
Jarman score (decile rank)	5	5	10	9
Life Expectancy (Male) (1999-2001)	LA1 – 73.1 LA2 – 74.1 LA3 – 75.2 LA4 – 75.9	LA1 – 76.3 LA2 – 76.7 LA3 – 76.7 LA4 – 77.3 LA5 – 77.0 LA6 – 77.9 LA7 – 78.0	LA1 – 73.3 LA2 – 73.6	LA1 – 74.7
Life Expectancy (Female) (1999-2001)	LA1 – 78.8 LA2 – 79.8 LA3 – 79.8 LA4 – 80.2	LA5 – 80.8 LA2 – 80.9 LA3 – 81.3 LA1 – 81.7 LA4 – 82.0 LA7 – 82.1 LA6 – 82.2	LA1 – 78.8 LA2 – 80.3	LA1 – 79.8
General health not good ¹	8.7%	7.8%	9.9%	10.0%
Unemployment ¹	2.7%	2.6%	5.2%	3.9%
Ethnic diversity ¹ (% population born outside UK)	2.2%	4.5%	24.6%	9.1%

¹ Using the 2001 Census statistics

Key

CC – County council
UC – Unitary council
BC – Borough council
DC – District council

Appendix G

Interview schedule

Main template for all interviews (adjusted for each sector)

A. Structure and organisation of local partnerships

1. Could you give me a brief description of the local health partnerships you are involved in, your role and the other organisations that are involved?
2. How is the (HImP/HAZ/HC/HFA/SRB) partnership structured? Why was it set up this way?
3. How is the partnership governed?
4. Have resources been identified for development of the partnership or its work? If yes, what are the sources of new money and where is it being directed? How shared are these resources? How can they be used and who has ultimate control over how they are used?
5. Does your organisation manage the work of other organisations in the partnership? If yes, and in what way?
6. How does the partnership inter-link with other health strategy partnerships in your area? (HImP/HAZ/HC/HFA/SRB)

B. Process – the developing the partnership

7. Why did your organisation decide to get involved in the HImP/HC/HAZ partnership? What was its motivation? (money/finance, kudos, information, uncertainty) (CHC, voluntary and private sector organisations)
8. Who was the initiator/convenor of the partnership? How did you decide which organisations to invite/involve in the partnership? (HAZ/HC)
9. How did the partnership decide how it was going to govern/organise itself and what it was going to do? How was the division between strategic direction and management of operational issues decided by the partnership? What were the influences that came to bear on this process?
10. Has the partnership defined its purpose or does it have a vision about the direction in which it is going? Has this been useful? Why?
11. How did the partnership decide which areas of health policy it should cover? How is its scope different to that of other local health partnerships (HImP/HAZ/HC/HFA/SRB)?
12. Have terms of reference been agreed? Have they been useful in the partnership's work? Have you had to call on them? If yes, when and why?

13. Which organisations have had the most influence on how the partnership was structured or has developed? Why?
14. What has been the influence of the central government policy or directive on the way the partnership has developed? [ask for examples] How much has it influenced your thinking on partnership?

C. Partnership management

15. How are decisions taken in the partnership?
16. How is the work of the partnership managed? Is there a performance management framework being used? What influence has the National Framework for Assessing Performance had?
17. Is the partnership being monitored (or evaluated) in any other way? If yes, how is this being done? What criterion is being used and how was this decided? What changes come about from this process? If none, why not?
18. How does accountability work within the partnership work? (structures/performance management) To whom are partners accountable? How was this decided? Has there been any conflict in the partnership between accountability to the partnership and accountability to individual organisations? If yes, how does this affect the partnership and its work?
19. Has the partnership developed or considered developing any specific plans to develop the partnership itself? If so, what are they?

D. Voluntary sector participation in partnership

I want to talk about voluntary sector participation in partnerships. By voluntary sector I mean voluntary organisations, user/carer groups, community groups and public

20. How was the level or degree of voluntary sector participation decided? What issues were considered in making the decision? Are you working with any voluntary organisations or community groups you weren't working with in the past?
21. What mechanisms are being used to involve the voluntary sector (voluntary organisations, community groups and public-at-large)? How is the public's view or voice 'heard' in the partnership?
22. Has the partnership developed or considered developing any specific plans to improve voluntary sector's participation in the partnership? If so, what are they and why these approaches?

E. Organisational change to accommodate working in partnership

23. What does it mean to you (or your organisation) when the government says you must work in partnership?
24. In what ways has your organisation changed to accommodate working in partnership? Have any additional structures been set up within existing organisations to complement the work of the partnership? i.e. to aid policy development, implementation, evaluation, monitoring.
25. Does your or any other organisations' responsibilities impinge on the partnership and its work? If yes, how and why? [i.e. the need to produce a JIP, SaFF, meet national targets etc]
26. Do you think there has been a 'real' change in attitude about what can be achieved through partnership? Why do you think this is so?

F. Influences on working in partnership (positive and negative)

27. What have been the main difficulties in trying to work with different organisations on the health agenda?
28. Have any features of your local area (population, economic, geographical) particularly influenced the development of the partnership or the way it functions? If yes, which and in what way?
29. Have any features of partner organisations (structural, historical, individuals) particularly influenced the development of partnership or the way it functions? If yes, which and in what way?
30. Have any cultural issues between organisations arisen which have impeded or enhanced the partnership or its work? (medical vs non medical, public vs private)
31. What's been the influence of the duty of partnership (to promote the economic, social and environmental well-being)?
32. Does the partnership need more resources? If yes, which and why?
33. Has the presence of another health partnership influenced the partnership's development or work?

G. Nature of relations between partners (interaction)

I now want to talk about how you relate to the other partners. First, your relationship with organisations before working in partnership.

34. Was your organisation working with any of the partners in any capacity before the partnership was formally established? Did that influence your decision to get involved? (non HA) (Not HC Co-ordinators).
35. When you entered into partnership were you fully aware of the kind of work that other partner organisations did? And the resources they had available to work on

strategic health issues? Did this make a difference to your attitude to get involved in partnership?

36. Does your organisation have aims and objectives which are similar those of other organisations in the partnership(s)? (not CHC)
37. Do you think there is an understanding in the partnership about the areas of work each organisation can contribute?
38. To what extent have previous relationships between organisations been important to the development of the partnership? Why?

I now want to talk about the nature of relationships between partners

39. How do partners communicate with one another? What formal/informal mechanisms are used? i.e. if you have a problem or issue you want to raise do you approach members of the partnership informal, for example, by the telephone or when you meet in other for wait for then next meeting? Have you been approached informally about an issue?
40. Have there been any instances of poor communication or misunderstanding? If so, why?
41. How committed to the partnership do you think other partners are? In what way do they show it?
42. Are or have any of the partners been obstructive or not full filled their obligations to the partnership? If yes, over what issue and why?
43. Are or have any organisations been reluctant partners (i.e. poor attenders at meetings) or withdrawn from partnership altogether? If yes, who and why?
44. Do you think your organisation will still be working in partnership with your partners in 2/3 years time? Why?
45. Are the resources that each organisation brings to the partnership made clear? Has there been any sharing of budgets or sensitive information (financial/patient data)/disclosure of self-interest?
46. Is your position/organisation funded (or given any other resource) by another member of the partnership? If yes, do you think this influences the way you have behaved in the partnership? How? (HC/HAZ/HImP sub groups)

Relationships with other partnerships – JCC, SRB/HC or HAZ.

47. Is your relationship as a member of the HC or HAZ partnership different to that in the HImP? If yes, in what way, and why? (Not HC Co-ordinators, CEOs) execs]

H. Impact of partnership on the health policy agenda

I now want to talk about the impact of partnership on the health agenda. First, on policy development and agenda setting.

48. How have you or your organisation contributed to the local health agenda?
49. How are issues or local needs identified and prioritised within the partnership?
How do they get onto the agenda?
50. Which individuals or organisations have been or are the most influential in shaping the policy agenda or implementation of policy? If so, how and which one(s)?
51. How much influence do the voluntary sector (voluntary, user/carer and community groups and the public), have on the shaping the agenda, either directly through groups representing their interests or otherwise?
52. Have there been any health issues or policies on the partnership's agenda over which there has been more contention than others? If yes, which and why? How have local priorities married with the national ones?
53. Have there been any discrepancies between those needs identified by the voluntary sector/community and those identified by health professionals? If yes, how was this resolved?
54. Can you recall an instance where you chose not to raise an issue at a meeting or where you felt your organisation was excluded from decision-making?
55. How does the health strategy of the HImP/HAZ/HAZ/SRBs differ or concur with that of other 'health' partnerships such as the HImP/HAZ/HAZ/SRBs?
56. Do you think there has there been any duplication of health issues in the HImP with any other health partnerships? Why?

I. What has been the output of partnership in relation to the health agenda?

I now want to talk about the impact of partnership on local health strategy.

57. Has your organisation contributed to the local health strategy in a way which it wouldn't have done before i.e. when there was no partnership/HImP? If yes, how? Can you give me an example?
58. What impact has working with a wide range of organisation had on the development of local health strategy and its implementation? Examples?
59. Can you give me an example of 'joined up thinking' or improved co-ordination within the partnership...and within the organisation?
60. Have there been any new/novel initiatives that you think would not have happened or come about if there wasn't a health partnership? Examples?

J. Influences on the implementation of policy

- 61. Has your organisation implemented any of the policies set out in the HImP/HAZ/HC?**
- 62. What factors have influenced the implementation of policies developed in partnership?**
- 63. Have any of the policies developed by the partnership been more difficult to implement than others? If so, which and why?**

K. Meeting the government's health agenda. The benefits of partnership working

- 64. What do you think you get out of, or have got, out of working in partnership? Is this the same for all the strategic health partnerships you have been involved in? What has been to down-side of working in partnership?**
- 65. Have your expectations about what you could achieve through partnership met? If not, why not? What about other organisations in the partnership?**
- 66. What have been the successes of partnership? What has not worked?**
- 67. What problems have you faced in meeting, or trying to meet, the government's health agenda through partnership?**
- 68. If you were involved in setting up the partnership again how might you do things differently? Why?**
- 69. What do you see happening in the partnership over the next year? And over the next three years?**

L. Finally, if there anything else you would like to say about the way partnerships you are involved in are run, operate or function but we have not covered?

Appendix H

Table profiling sector and seniority of interviewees

Interviewee profile	Dalesville	Greenshire	Metrocity	Middleton	Total
HIMP/HAZ/HC/HFA Co-ordinators	4	1	5	1	11
Health authority – Senior	2	1	3	0	6
Health authority – Operational	1	0	1	3	5
Health authority (DPH/DHP)	3	2	1	1	7
Health authority (DPH/DHP)	3	2	1	1	7
NHS Trust (Acute) – Senior	0	1	0	1	2
NHS Trust (Community) – Senior	1	1	1	1	4
PCG/PC – Senior	3	2	2	2	9
Local Authority (SS) – Senior	1	1	1	1	4
Local Authority (Environment/ Housing/Leisure) – Senior	2	3	0	3	8
Local Authority (Corporate/SRB)	0	1	3	2	6
Local Authority (Education)	0	0	0	0	0
CHC – Senior	1	1	0	1	3
CHC – Senior	1	1	0	1	3
Voluntary Sector –Senior	3	3	3	2	11
Probation – Senior	0	1	0	1	2
Private Sector	0	0	0	0	0
Total	21	19	20	21	81

Table profiling observation work in case study sites

Observation	Dalesville	Greenshire	Metrocity	Middleton	Total
HIMP/HAZ meetings	1	4	3	2	10
Review days	0	2	1	0	3

Appendix I

Observational proforma for partnership meetings

Partnership group:

Date:

Venue:

Number of people:

Observations to address:

Who's present? Which sectors?

HA

LA

Trusts A/C

PCGs

CHC

Vol

Other

1. Who is the chair? Is it revolving?
2. What's the purpose of the meeting?
3. How are attitudes transmitted?
4. How do people relate to one another?
5. Key issues discussed?

6. Are differences of opinion expressed, and over what?

7. Who talks? Who doesn't? Who speaks but is not heard?

8. How is the group managed by the chair? What is the influence of the chair?

9. How are decisions taken?

10. Other comments/observations about the group's interaction/decision-making etc

Meeting table plan sheet:

Appendix J

Perceptions of partnership. A documentary analysis of Health Improvement Programmes

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Health Improvement Programmes (HImPs) are at the heart of the UK government's partnership agenda for the National Health Service (NHS). This paper assesses the nature of HImP partnerships in England by analysing 50/99 first-round HImP strategies (randomly selected). The documentary analysis quantifies the structures and mechanisms of partnership, the degree of inter-sectoral participation and the extent of voluntary sector involvement.

Three-quarters of responding health authorities (37/50) appear to have set up formal partnership structures to produce the HImP, or are planning to do so. After health authorities, local authorities (47/50) appear to be most involved in contributing to the HImP, particularly social services departments. Within the NHS 'family', acute and community trusts (43/50) appear to be the most involved, with Primary Care Groups (PCGs) contributing less (39/40). Community Health Councils (CHCs) appear to be similarly involved (40/50). The voluntary sector appear to be involved in all but four HImPs, mainly through umbrella organisations represented on strategic partnership boards (34/50). User and carer and community groups appear to participate far less. Lack of endorsement of HImPs by partner organisations, poor delineation of responsibilities and absence of transparency in resource allocation suggest that ownership of, and commitment to HImPs may be weak. HImPs appear to have focused on creating structures rather than developing aspects of partnership process. If levels of inter-sectoral involvement and voluntary sector participation are to be maintained or increased in future, Primary Care Trusts (PCTs) will need to develop a strategic approach to partnership.

Public Health (2002) 116, 207–213. doi:10.1038/sj.ph.1900856

Keywords: Health Improvement Programme; partnership; participation; documentary analysis; Primary Care Trust

Introduction

Partnership is an important feature of New Labour's 'Third Way' politics. Reference to partnership can be found consistently in a raft of government policy guidance, legislation and exhortation.¹ The White Papers, *The New NHS: Modern, Dependable*² and *Saving Lives: Our Healthier Nation*³ both placed partnership at the centre of government health service reforms. Partnership is now one of the core principles underpinning the changes in the NHS and the means by which the national health strategy is to be delivered locally.^{2,4}

A key element of the government's partnership agenda in the National Health Service (NHS) is Health Improvement Programmes (HImPs). These are three-year local health strategies produced in partnership with a wide range of stakeholders from within and beyond the health service, under the stewardship of local health authorities, to improve the health of the local population and redress local

inequalities in health and social care and health provision. Recent guidance has extended their scope to include the NHS modernisation agenda, renaming them Health Improvement and Modernisation Plans (HIMPs).⁵ With the creation of Strategic Health Authorities (StHAs) in April 2002, Primary Care Trusts (PCTs) are now the lead organisation for developing the strategy, building on previous partnership arrangements.⁶

One of the priorities of HImPs in the first year, aside from selecting a number of national and local issues and developing an action plan to tackle them, was to build and strengthen local partnerships.⁷ To this end, the government has placed a duty of partnership on NHS Trusts, Primary Care Groups (PCGs) and local authorities to encourage their involvement.^{8,9}

However, partnership is a contested concept. It means 'different things at different times and in relation to different groups'.¹⁰ Since government documentation is not specific about what partnership is – no definition is given, and guidance is not prescriptive – there is considerable flexibility with regard to format and structure.¹¹

This study sought to establish what kinds of HImP partnerships were developing in England, particularly the prevalence of different partnership structures, the degree of inter-sectoral involvement and the extent of voluntary

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Accepted 25 April 2002

sector participation in first year HImPs. It forms part of a wider study to evaluate the role of partnership in the development and implementation of local health strategy in England.

There has only been a handful of published studies of HImPs to date (although research is in progress).¹² These have taken either a comparative case study^{11,13–15} or survey approach¹⁶ to identify the issues and difficulties that HImPs have experienced during their first year, or they have analysed the content of HImP programmes in relation to specific priority areas, such as coronary heart disease,¹⁷ children's health,^{18,19} obesity²⁰ or against national guidance²¹ or a Donabedian-type framework.²² There has also been a parliamentary report.²³

In general, these studies have reported a positive response to HImPs across all sectors and much goodwill and enthusiasm, especially for working in partnership.^{13–16} However, several issues regarding the development of HImPs have been identified, including: short timescale and late guidance; poorly defined roles and responsibilities; lack of clarity regarding accountability and performance; poor co-ordination of plans and funding streams between the NHS and local government; resource constraints; wide variation in preparedness of organisations; difficulties in involving stakeholders within and beyond the NHS; lack of organisational and community capacity to sustain wider participation in the process; the tension between local and national priorities; different understandings of what health improvement means; and uncertainty over how to measure progress in improving health.²¹

However, these studies were based on small numbers of HImPs (between five and seven), with mixed selection criteria, and a limited degree of participation from statutory organisations and the voluntary sector. Generalising the findings of these studies to other HImPs in England is therefore questionable. Studies analysing the content of HImPs, on the other hand, have not adequately addressed partnership working or inter-sectoral participation.

Since it is through partnership that local HImPs are shaped and delivered, understanding the extent and nature of partnership working in HImPs across England will be crucial if HImPs are to achieve their aims.⁹ This study uses documentary analysis to build on previous work, providing a broader picture of HImP partnership development in England and a baseline by which to chart future progress. However, it is worth noting the limitations of this methodology. First, it is important to recognise that the policies, procedures and structures outlined in the HImP may not be a 'true' reflection²⁴ of local partnership or practice, or indicate that the policies contained within it are being implemented.²¹ It is also a document produced for external consumption.²⁵ Consequently, its contents are likely to be shaped by what each of the constituent partners perceive to be important or expected. This will be influenced by differing social, political and economic pressures acting at both local and national levels.²⁶ Further, the priorities of researchers and those of the HImP partnership may not

concur:²¹ what is interesting to the researcher may not be mentioned in the HImP. Nevertheless, the production of HImP strategies is integral to partnership work and their contents are declarations of intent and a public commitment to certain values and objectives.²¹

Methods

A random sample of 50 of the 99 health authorities in England was selected for the survey and checked for representativeness, based on Jarman Underprivileged Area Score, ONS Area Classifications, local authority type and other health partnerships.

This sample size was considered to be sufficiently representative for analysing documents and interpreting the results. A copy of the first round HImP was requested for the period 1999/2000. Follow-up telephone calls to the Directors of Public Health for non-responding authorities ensured a 100% response rate.

The analysis of the HImP documents involved a five-stage process.^{27,28} Central to this approach was the development of the analytic tool, a pro forma which addressed a series of questions to the text based on a conceptual model of partnership. Although no widely agreed definition of partnership was identifiable in the literature, a number of common activities or characteristics of partnership are described. The conceptual model used in this study was based around these, and essentially views partnership as both a form of organisation (*structure*) and a method of working (*process*).²⁹ Structure can be conceptualised as *form* and *membership*, while two key aspects of process can be considered as *participation* (of relevant stakeholders,³⁰ especially the voluntary sector) and *interaction*. Interaction concerns the quality and dynamic of relations between partners. Given the difficulty of gauging the degree of interaction from the text, several proxy indicators were developed to assess this concept. These were based on questions around shared or equal ownership, clear roles and responsibilities,³¹ and organisational commitment^{32,33} all identified in the literature as essential elements of partnership working.

Details regarding local demography, local authority structures and the presence of other local health partnerships were also recorded.

Results

Of the 50 HImP documents received, 39 were final versions, 9 were draft HImPs and 2 were early consultative documents for second round HImPs (but clearly based on first-round documents). Four documents were joint HImP/Health Action Zone (HAZ) strategies and just over half (27/50) were three-year strategies. The sample also represented just under half of those health authorities with a HAZ (16/34). As health authorities were at different stages in

developing HImP strategies and adopted different approaches, it was decided to include all documents in the analysis so as to provide a snapshot of partnership at a point in time, rather than at a specific stage of document production.

Documents varied considerably in size (between 31 and 230 pages, average length 81 pages excluding appendices), style (from glossy documents written for a public audience (20/50) to plain, functional documents for internal use (24/50)). They had clearly been produced with different audiences and uses in mind.

Partnership structures and membership

The majority of the health authorities (60%, 30/50) appeared to have set up new, formally constituted, partnership structures to produce the HImP. Of the 17 HImPs without new structures, 41% (7) were planning to establish them in the coming year. One-fifth of all responding HImPs (10/50) appeared to have no plans for new partnership structures. However in some of these areas, existing partnership structures or arrangements appeared to be in use.

Despite a lack of information and detail on partnership structure in the documents—only 12/50 HImPs included a diagrammatic representation of HImP structures—there appear to be two main forms of partnership: three- and two- (one-third of HImPs appear to have adopted the latter). Generally, three-tier partnerships appear to have a *board* or *reference group* to provide strategic direction, *steering* or *programme group* to 'take a view on how best to integrate policy and action' and *working groups*, based around local priorities or localities or both, to put plans into action. In two-tier HImPs, the functions of the reference and programme groups tend to be merged into one tier.

Many of these structures were health authority wide, but in a number of districts structures were based on local authority or PCG boundaries. In some cases, there was a linking structure to co-ordinate programmes between areas.

There was generally little or no information in HImPs on who chaired these new structures, where the chair was based or whether non-executive members of the health authority were involved. However, in a third of HImPs (17/50) the Director of Public Health (DPH) or associate/assistant DPH appeared to have taken on the lead or co-ordinating role. Only one health authority chief executive appeared to have taken on the lead role.

Furthermore, the relationship of other health partnerships such as HAZs (16/50) to the HImP, was not clear in many documents where these partnerships were present. For example, the HAZ was seen as the delivery mechanism for achieving HImP priorities in half the health authorities (8/16) but governance arrangements over programme development and implementation or links between the two partnerships were only outlined in three documents. However, there was wide recognition that the relationship between these partnerships would evolve or become more integrated in the future.

Few HImPs mentioned the relationship between the HImP to the Joint Consultative Committee (JCC) or Joint Planning Groups (JPG). In the few that did, their role was under review or recast as the HImP.

The data showed no association between different structural arrangements and specific demographic, structural or partnership characteristics of health authorities.

Contribution to HImP

Figure 1 shows the frequency of contribution of different organisational sectors to the HImP, either directly through membership of the top tiers of partnership structures (ie not through working groups) or through other less formal mechanisms such as *ad hoc* editorial groups. Many HImPs listed contributors but details on contributors' roles and responsibilities were often absent.

Apart from health authorities, local authorities appeared to be most involved in HImPs, with some or all councils contributing to them in 94% (47/50) of health authorities.

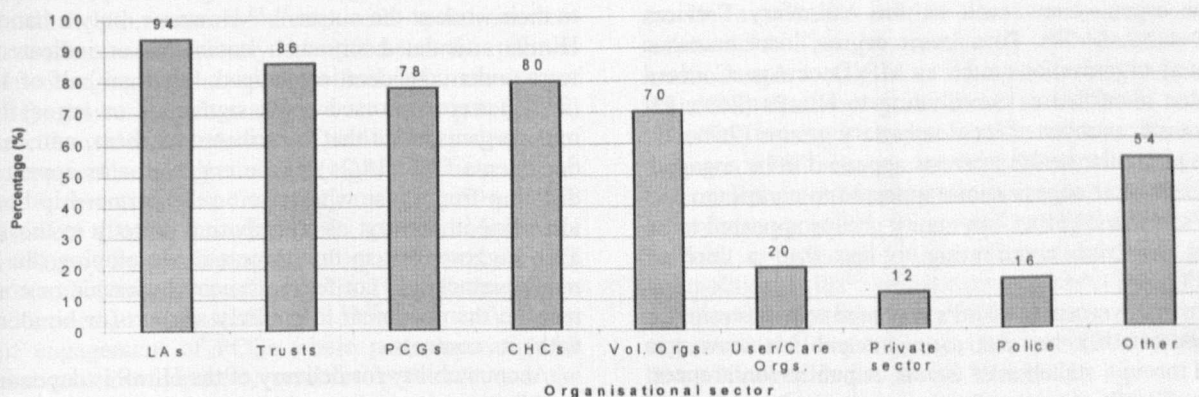


Figure 1 Frequency of contributions to HImPs by organisational sector.

58% (29/50) of HImPs did not specify which departments had been involved. Of those which did, social services appeared to be the most likely department to contribute (38%, 19/50), followed by the Chief Executive or corporate planning office (20%, 10/50) and education (16%, 8/50). Housing (14%, 7/50), environment (12%, 6/50) and leisure departments (4% 2/50) appeared least likely to contribute.

Within the NHS 'family', acute and community trusts appeared to be the most involved in HImPs, contributing in 86% (43/50). PCGs or GP representatives from 'shadow' PCGs appeared to have been less involved (78%, 39/50). PCGs are identified as key partners in planning and developing HImPs but few documents mentioned PCGs' own priorities and even fewer included PCGs' Primary Care Investments Plans. Many HImPs recognised the difficulties and slowness of engaging PCGs, many of which were still in the formative stages of development, and resolved to increase their contribution in the second HImP. Community health councils (CHCs) were well represented, contributing or observing in 80% of HImPs (40/50).

Other sectors contributing included: local medical or other representative committees (24%), race and ethnicity forums/councils (14%), police (14%), probation (12%) and universities/colleges (12%) and to a lesser degree NHS regional offices, HAZs, Drug Action Teams, Single Regeneration Budget partnerships, Training and Enterprise Councils and Health and Safety Executive.

Voluntary sector participation

Government guidance stressed the need for HImPs to be an inclusive process with the widest possible local involvement from the outset,^{7,34} and involving both local service providers and users and other organisations with an interest or a contribution to offer.⁷

This study considered the voluntary sector to include voluntary and users/carer organisations, community groups and the public. Figure 2 shows that of this group, voluntary organisations contributed most to HImPs (86%, 43/50); only four did not appear to involve voluntary groups. The most frequently cited voluntary organisations were umbrella organisations such as the Voluntary Services Council (68%, 34/50). To a lesser degree, local branches of national organisations such as MIND or Age Concern were often identified as contributing to HImPs (26%, 13/50). A similar number of local voluntary groups (26%, 13/50) with particular health interests appeared to be engaged.

User and carer organisations appeared to contribute less to HImPs (48%, 24/50). Community groups appeared to be the least involved, contributing to less than a third of HImPs (15/50).

Public involvement in HImPs appeared to be of a similar magnitude (16/50). In most cases the public's view was solicited through stakeholder events or public conferences. In a few HImPs, more sophisticated methods were used such as citizens' panels and surveys. In four health autho-

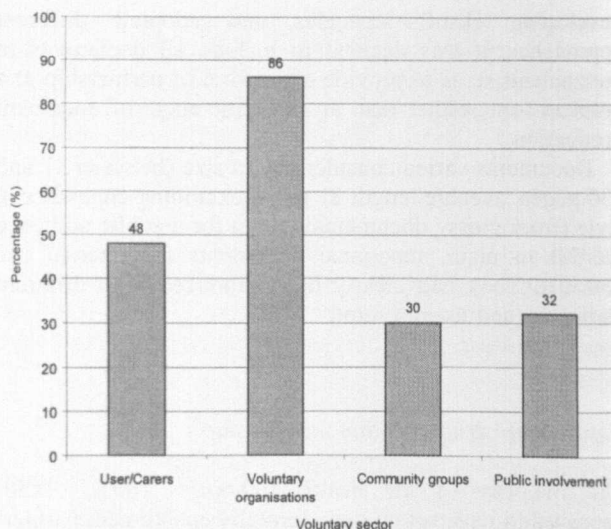


Figure 2 Frequency of contributions to HImPs by voluntary sector.

rities, the content of the HImP was published in the media, and in two HImPs, the CHC took an active role in engaging the public.

However, only 50% of HImPs (25/50) contained a glossary and even fewer (40%, 20/50) contained an invitation to comment on the contents, leaving doubts as to whether patients, community groups or members of the public would understand its content or respond. Only a few health authorities mentioned producing the HImP in minority languages or in a format accessible to people with visual impairment. Just over half of HImPs (26/50) contained a strategy to develop or support partnership and only one-third (16/50) a strategy to support voluntary sector participation.

Partnership process

A key developmental stage to becoming a successful collaboration is for partners to agree a vision or purpose to their work at the outset.^{31,35} However, only a handful of HImPs articulated any such statements or indicated they were under consideration. Indeed, less than half of HImPs (24/50) were endorsed (with signatures or logos) by the main organisations that contributed to them, and in these documents 58% (14/24) of the endorsements appear to be different from those who were on the partnership board or identified in the text as contributing directly to the HImP. This suggests that in the process of developing the HImP many partners did not feel sufficient ownership or commitment to the document to publicly support (or be identified with) its contents.

Accountability for delivery of the HImP is dependent on establishing clear roles and responsibilities of partners. But in a third of HImPs (17/50) no clear programme of action

was presented, and in those HImPs that did, the programme was often far from comprehensive. For example, just over half of HImPs (28/50) identified a lead organisation for each action point in their programme, only two-thirds of HImPs (34/50) had set timelines by which to accomplish their commitments and only one in six (8/50) assigned resources to each element of the programme. Less than a quarter of HImPs (12/50) mentioned the possibility of joint budgets and even less appeared to have co-financed projects. Only two HImPs—both with HAZ status—explicitly identified funding for the development of partnership, public participation or community involvement.

Discussion

Documentary analysis can provide a useful insight into how partnerships are developing. However, it is important to recognise the limitations of this methodology when drawing conclusions (see Introduction). With these in mind, this study indicates that some first-round HImPs are wide ranging in their emphasis on partnership, vary considerably in structure, membership, and degree of voluntary sector participation. Their differential development appears to be contingent on previous experience of partnership working, local circumstance and how much partnership is recognised as key to delivering the national health agenda.

Such variety probably reflects the lack of central guidance on what partnership should be, which leaves considerable scope for local interpretation and development at a pace commensurate with local circumstances and experience. This may be entirely appropriate.

Engagement of key stakeholders is essential if collaborative activity is to be successful.³⁵ To this end, government guidance on which sectors to involve in HImPs was relatively explicit (although far less explicit about how to involve these sectors in identifying and prioritising local health issues). However, these results show that involvement of organisations within and beyond the health sector has been far from universal. It is encouraging that local government appears to have contributed to the HImP in nearly all health authority areas, with social services departments most frequently identified as the partner. Less encouraging is the apparent lack of inclusion of other departments which may have an equal potential to influence the wider determinants of health, a key element of the government's strategy for reducing health inequalities.³

Two further concerns, frequently recognised by HImP authors, were that one in seven HImPs appeared not to have involved trusts in developing the programme and an even greater number failed to engage PCGs. These findings have been identified in other studies,^{11,15,16,22,28} particularly the lack of engagement of PCGs where preoccupation with organisational development, resource pressures and the push to gain trust status appears to have restricted their capacity to participate.^{13,15,22}

HImPs also appear to have achieved mixed results in achieving a voluntary sector participation in decision making, an issue identified in other studies.^{11,13–16,21,22} This is notoriously difficult to achieve,¹³ but particularly important to accomplish when the purpose of partnership working is to develop 'user-based' rather than 'producer-led' services.³⁶

While the majority of HImPs appear to have developed (or are planning to develop) new structures, the focus on formal working relations appears to have been to the detriment of important elements of the partnership *process*; few HImPs had developed a vision for the partnership; there was a low level of endorsement of HImP contents by partners, poor assignment of responsibilities in action plans, and a low level of resource commitment.

The critical role of *process* in ensuring the success of inter-sectoral collaboration is frequently underestimated.³⁵ As Costongs and Springett note, the effectiveness of partnership is as much about the process by which the outcomes are achieved as it is about the outcomes of partnership.³⁷

This documentary analysis raises concern about the level of inter-sectoral involvement and the degree of engagement of partners in the process of producing HImPs. While many health authorities have made great strides in this area, HImPs appear to lack a systematic and strategic approach to involving key stakeholders and developing the partnership.

However, HImPs were produced to a very tight timetable, with many partnerships still at their earliest stages when they were required to produce their first report.¹³ This placed limits on what could be achieved, as recognised in the documents themselves. The findings of this documentary analysis perhaps reflect this.

Nevertheless, the findings raise concerns and challenges for PCTs as these organisations become the focus of local partnership and HIMP production. PCGs were only required to have one representative from social services on their Boards. If HImPs are to improve health (and not just lead to better integration of health and social care⁶), then PCTs will need to involve other local authority departments which impact on the determinants of health, something which the majority of first round HImPs failed to do. PCTs will also need to increase the involvement of acute trusts. This is strategically important since most health care resources are tied up in acute hospitals, and without their co-operation it will be difficult to redirect resources into health improvement and away from secondary care.¹⁴ PCT Boards are heavily populated by general practitioners, a profession whose culture has not been one of collaboration.^{28,38} Even with an appropriate attitude, working in partnership requires communication, planning, and political skills³⁷ which many individuals in PCTs may not possess. Furthermore, PCTs still face many of the organisational constraints which prevented PCGs from being involved in first round HImPs.

Collaboration requires careful attention to both membership and process factors if it is to be successful.³⁵ This

needs a strategic approach backed by corporate commitment, particularly when the collaboration involves the voluntary sector. Such an approach will enable PCTs to address the lack of skills and competencies of staff, the dominance of professional culture, and the capacity of partners and PCTs to engage.³⁹

PCTs present an opportunity to build new partnerships which are more locally focused and sensitive to local needs. However, failure to tackle the above challenges above may quickly lead to disenchantment with the process and disengagement of partners, leaving PCTs dominating the agenda in a style reminiscent of past bureaucratic planning approaches.¹⁵

Lessons for the future

- HImPs provide a good focus for partnership working and can enable the development of positive relationships between the statutory and non statutory sectors.
- HImPs need to ensure that stakeholders beyond NHS trusts and social service departments are involved.
- HImPs need to actively support the inclusion of the voluntary sector, particularly community groups.
- HImPs need to pay attention to the *process* aspects of partnership.
- PCTs need to take a strategic approach at a corporate level to ensure that all stakeholders are fully engaged.

Acknowledgements

This work has been supported by an NHS Executive London Region Research and Development Research Fellowship.

References

- 1 Glendinning C, Clarke J. Old wine, new bottles? Prospects for NHS/local authority partnerships under 'New Labour'. *Paper Prepared for the ESRC seminar on 'The Third Way in Public Services—Partnership'*. University of York, 2000.
- 2 Department of Health. *The New NHS: Modern, Dependable*. Stationery Office: London, 1998.
- 3 Department of Health. *Saving Lives: Our Healthier Nation: A Contract for Health*. Stationery Office: London, 1999.
- 4 Department of Health. *The NHS Plan. A Plan for Investment. A Plan for Reform*. HMSO: London, 2000.
- 5 Department of Health. *Health Improvement and Modernisation Plans (HIMPs): Requirements for 2002*. NHS Executive: Leeds, 2001.
- 6 Department of Health. *Shifting the Balance of Power within the NHS. Securing Delivery*. HMSO: London, 2001.
- 7 Department of Health. HSC 1998/167. *Health Improvement Programmes. Planning for Better Health and Better Health Care*. NHS Executive, 1998.
- 8 Department of the Environment, Transport and the Regions. *Modern Local Government: In Touch with the People*. HMSO: London, 1998.
- 9 Department of Health. *Our Healthier Nation: A Contract for Health*. Stationery Office: London, 1998.
- 10 Walker A. *Community Care: the Family, the State and Social Policy*. Blackwell and Robertson: Oxford, 1982.
- 11 NHS Executive London Regional Office. *London's Health Improvement Programmes. Findings from the First Phase of Development 1998/99. Final Report*. NHS Executive London Regional Office, 1999.
- 12 Hamer L. *Health Improvement Programmes: Research into Practice. A Briefing for Local Partnerships Involved in Health Improvement Programmes*. Health Development Agency: London, 2001.
- 13 Arora S, Davies A, Thompson S. *Developing Health Improvement Programmes. Lessons from the First Year*. King's Fund, 1999.
- 14 Arora S, Davies A, Thompson S. *Developing Health Improvement Programmes: challenges for the new millennium*. *J Interprof Care* 2000; **14**: 9–18.
- 15 Carruthers I, Shapiro J, Knight T. *Improving HImPs. The Early Lessons*. Health Services Management Centre, School of Public Health. University of Birmingham, 1999.
- 16 Geller RJ. The first year of Health Improvement Programmes; views from Directors of Public Health. *J Public Health Med* 2001; **23**: 57–64.
- 17 National Heart Forum. *All Party Parliamentary Group on Primary Care and Public Health Inquiry into Health Improvement Programmes, December 1999*. Written evidence by the National Heart Forum. National Heart Forum: London, 1999.
- 18 NSPCC, the Children's Society and the National Children's Bureau. *Improving Children's Health: A Survey of 1999–2000 Health Improvement Programmes*. NSCPC, 1999.
- 19 Underdown A, Sexty C. Getting the hump with HImPs. *Health Service J* 2000; **110**: 22–24.
- 20 National Audit Office. *Tackling Obesity in England*. Report by the Comptroller and Auditor General. National Audit Office. The Stationery Office: London, 2001.
- 21 Abbott S, Gillam S. HImPs. Trusting to luck. *Health Service Journal* 2000; **110**: 24–25.
- 22 Hamer L. *National Review and Analysis of Health Improvement Programmes 1999–2000 (Report)*. Health Development Agency: London, 2000.
- 23 All Party Parliamentary Group on Primary Care and Public Health. *Report of An Enquiry into Health Improvement Programmes*. House of Commons: London, 2000.
- 24 Silverman D. *Interpreting Qualitative Data. Methods for Analysing Talk, Text and Interaction*. Thousand Oak/Sage: London New Delhi, 1993.
- 25 Atkinson P, Coffey A. Analysing documentary realities. In: Silverman D (ed). *Qualitative Research. Theory, Method and Practice*. Thousand Oaks/Sage: London New Delhi, 1997.
- 26 Miller G. Contextualising texts: studying organizational texts. In: Miller G, Dingwall R (eds). *Context and Method in Qualitative Research*. Thousand Oaks/Sage: London New Delhi, 1997.
- 27 Appleton JV, Cowley S. Analysing clinical practice guidelines. A method of documentary analysis. *J Adv Nursing* 1997; **25**: 1008–1017.

- 28 Department of Health. *The Health of the Nation—A Policy Assessed*. Stationary Office: London, 1998.
- 29 Hutchinson J, Campbell M. *Working in Partnership: Lessons from the Literature*. Department of Education and Employment, 1998.
- 30 Gray B. Conditions facilitating interorganizational collaboration. *Hum Relations* 1985; **38**: 911–950.
- 31 Cameron M, Cranfield S. *Unlocking the Potential. Effective Partnerships for Improving Health*. NHS Executive North Thames: London, 1998.
- 32 Delaney F, Moran G. Collaboration for health: in theory and practice. *Health Educ J* 1991; **50**: 97–99.
- 33 Webb A. Coordination: a problem in public sector management. *Policy Politics, Bristol* 1991; **19**: 229–241.
- 34 Department of Health. *Modernising Health and Social Services. National Priorities Guidance 1999/00–2001/02*: Department of Health, 1998.
- 35 Gray B. *Collaborating. Finding Common Ground for Multi-party Problems*. Jossey-Bass: London, 1989.
- 36 Department of Health. *Partnership in Action. New Opportunities for Joint Working between Health and Social Services. A Discussion Document*. Department of Health, 1998.
- 37 Costongs C, Springett J. Joint working and the production of a City Health Plan: the Liverpool experience. *Health Promotion Int* 1997; **12**: 9–18.
- 38 Callaghan G, Exworthy M, Hudson B *et al*. Prospects for collaboration in primary care: relationships between social services and the new PCGs. *J Interprof Care* 2000; **14**: 19–26.
- 39 Pickin C, Popay J, Staley K *et al*. Developing a model to enhance the capacity of statutory organisations to engage with lay communities. *J Health Service Res Policy* 2002; **7**: 34–42.

Appendix K

Table showing the mechanisms of mandatory co-ordination used by the New Labour government

Formal mechanism	Activity
Legislation	<ul style="list-style-type: none"> • White Papers • Health Act (1999), creating new decentralised organisational structures (PCGs) • Local Government Act (2000)
Circulars	<ul style="list-style-type: none"> • Policy documents • Health Service Circulars (HSC)/Local Authority Circulars (LAC) • Directives
Default power	<ul style="list-style-type: none"> • Ministerial intervention for failing organisations
Inspection	<ul style="list-style-type: none"> • Audit with performance graded using traffic lights and then stars
Appellate functions	<ul style="list-style-type: none"> • HAZ bids
Financial measures	<ul style="list-style-type: none"> • Regulating and scrutinising expenditure, particularly with regard to HAs, PCGs and HAZs
Judicial control	<ul style="list-style-type: none"> • New duty of partnership for NHS and local authorities • Freedoms and flexibilities increase statutory remit through pooled budgets, provision of NHS and Social Services. • Requirement to have Joint Consultative Committees (JCCs) rescinded

* Schema developed from Greenwood (1989).

Appendix L

Table showing examples of incoherence in the command and control mechanisms used by government

Co-ordination mechanism		Examples		Impact (site)
Command	Locus of incoherence			
New policy goals	Policy goals on health and partnership not joined up	<ul style="list-style-type: none"> Lack of clarity on how HImP strategies/partnerships should link with new non-mandatory strategic health and regeneration partnerships (i.e. HAZ, Pathfinder, NDC, EdAZ), many of which were based in LAs. 	<p>'Puzzlement' over how health partnerships which emphasise the determinants of health should fit with economic/regeneration partnerships, leading to some duplication of structures (DV, MC, MT, GS).</p>	
	Differing policy goals or priorities between departments	<ul style="list-style-type: none"> Prison health was a priority for the Home Office but not initially identified as a local priority by the DoH. The NRS did not refer to the recommendations in the MacPherson Report (1999) or CRE standards on tackling racism in government institutions. 	<p>HAs in a dilemma as to whether to include prison health in their strategic health plans (MC, GS, MT).</p>	
	Differing policy goals or priorities within the DoH	<ul style="list-style-type: none"> Whole Systems Thinking (WST) promoted in national directives and HAZ guidance but was absent in the DoH's strategies on sexual health, teenage pregnancy and drugs. Increased NHS funding for waiting lists without concomitant levels of funding for social services showed lack of WST between departments. Mental Health NSF was service-orientated and focused on severe rather than mild mental illness. It was 'very woolly on health promotion and prevention', failing to reinforce the government's broader policy goal of health improvement. 	<p>Missed opportunity to integrate strategies which influence young people's health at a local level (MT).</p> <p>Undermined efforts to reduce waiting lists as social services lacked resources to accept 'bedblockers' (GS).</p> <p>Different partnership sub-groups emphasising different perspectives on health (GS, MC).</p>	
Existing policy goals	Policy goals on health and partnership not joined up	<ul style="list-style-type: none"> Lack of clarity on how HImP strategies/partnerships should link with existing non-mandatory health and strategic community partnerships. 	<p>Upgrading of HC to strategic partnerships in 2 sites created duplication of role for senior officers and puzzlement over how to link with the HImP (DV, MC). Duplication with existing strategic community partnership (MT). Dissolution of HFA type partnerships and loss of existing social networks (GS).</p>	
	Incongruence	<ul style="list-style-type: none"> Lack of clarity on how HImP strategies (as well as JIPs and PCIPs) should link with existing statutory plans or strategies i.e. Community 	<p>Time and energy spent puzzling over how to link</p>	

	with existing policy goals	Care Plans.	strategic plans reduced capacity for HImP development (GS).
		<ul style="list-style-type: none"> Poor timing of funding streams (apart for ABIs) to support the policy goals. A previous government goal of reducing bureaucracy and thinning down NHS management structure. 	More difficult for HImPs to develop and plan a programme of action (DV, MC, MT, GS). Led to increased pressure on staff, reducing time available for engaging in partnership (GS).
Other existing formal co-ordinating mechanisms	Different planning cycles	<ul style="list-style-type: none"> Lack of synchronicity between HA and LA planning and budgeting timetables, particularly around the HImP and SaFFs 	Resulted in resources being allocated before HImP strategies were finalised. There was also lack of time to develop relations (DV, MC, MT, GS).
	Different boundary requirements	<ul style="list-style-type: none"> Home Office regulations specify that DAT partnerships are borough, not HA district based. 	Duplication of work for HAs with more than one borough (i.e. 2 case study sites) (DV, MC, GS).
Control			
Targets and standards	Differing department targets	<ul style="list-style-type: none"> Targets on accident reduction in the OHN and those from the Health and Safety Executive were not aligned. District level targets for drug policy set by the Home Office were different to those issued by the DoH in the National Priorities Guidance. 	Confusion over which target to work to. Different targets may require different programmes of work to be achieved (GS).
Monitor performance	Differing departmental requirements and indicators	<ul style="list-style-type: none"> Local organisations not performance monitored against the HImP but against own department's indicators. Some LA departments did not have the tools by which to assess their work (i.e. on transport). Performance indicators for ABIs not consistent between government departments. 	Different reporting times for ABIs created extra work, particularly for HAZ partnerships (DV, MC)
Evaluation and feedback	Differing accountability mechanisms	<ul style="list-style-type: none"> Departments responsible for ABIs employed different and separate monitoring and accountability systems. 	ABIs deterred from setting up joint projects on cross-cutting health issues as separate reporting mechanisms used up valuable resources (DV, MC).
Use of incentive and sanctions	Different incentive structures	<ul style="list-style-type: none"> The Fire Service was remunerated by the number of fires attended. This provided a perverse incentive against the Service getting involved in HImP prevention work, as a successful outcome might threaten their income. 	Although a theoretical discrepancy, in practice this was not sufficient to block involvement (GS).

Key for sites: DV-Dalesville, MC-Metrocity, Middleton-MT, GS-Greenshire

Appendix M

Table summarising respondents' perceptions/attitudes towards health and partnership by organisation/sector

Organisation /Sector	Broad systems	Narrow, biomedical	Analytical commentary
HA – All	Mixed	Mixed	Depended on department.
HA – Finance	Minority	Majority	Lacked understanding of population perspective and community involvement.
HA – PH	Mixed	Mixed	Understand population perspective but not very strong on partnership.
HA – HP	Majority	Minority	Good understanding of social model of health and experience of community involvement.
LA – SS	Majority	Minority	History of joint working on health. More directly affected by health. Some experience of partnership working, particularly with users/carers.
LA – EH	Mixed	Mixed	Some officers/departments interpreted health as environmental enforcement issue while others had more of a tradition of working on broader health issues, including prevention.
LA – Leisure	Mixed	Mixed	Exercise generally understood in terms of individual lifestyle although a few examples of a broader perspective which considers access (i.e. to OP) and population health.
LA – Housing	Mixed	Mixed	Some officers understood the connection between housing and health. Many others did not see the relevance.
LA – Education	Minority	Minority	Primarily focused on academic achievement. Few made the link between health and learning.
LA – Members	Mixed	Mixed	Health was generally seen as health service work, except for those with particular interest in health.
Trusts – Acute/MH	Minority	Majority	Mainly focused on individual and clinical services rather than health outcomes or populations. Little experience of partnership and generally poor links with SS.
Trusts – Community	Mixed	Mixed	Although focused on services, officers tended to have a broader understanding of health, with some experience of partnership.
PCGs	Mixed	Mixed	View dependent on CE and Board. GPs tended to lack population perspective although engaged in some prevention work (i.e. in GP contract).
CHCs	Majority	Minority	Although focused on health service issues, many officers understood the importance of working on the wider agenda despite not being in their remit.
Others (Probation, REC)	Majority	Minority	Some individuals understood and welcomed the broader perspective on health and partnership.
Voluntary Sector	Majority	Minority	Generally understood and welcomed the broader perspective on health and partnership.

Appendix N

Structure of HImP and HAZ partnerships in each case study site

The following four pages contain the HImP and HAZ partnerships maps for each study site. These maps give an indication of the size and complexity of partnership structures. It must be noted that these partnership structures were not static but were evolving in response to the national agenda and local context. The diagrams represent an approximate snapshot of the structure over the time of data collection in each study site. In many cases, the map was developed from an assimilation of partnership diagrams collected from each study site and information gleaned from interviewees. Most respondents were familiar with the structure of the partnership groups in their area but unsure about the wider picture. Similarly, diagrams were often aspirational or normative, often not reflecting the structures on the ground. A number of partnership groups were reported as temporary as restructuring was in progress. The diagrams, therefore, do not provide definitive maps of partnership in each site but give an overall impression of the partnership structure.

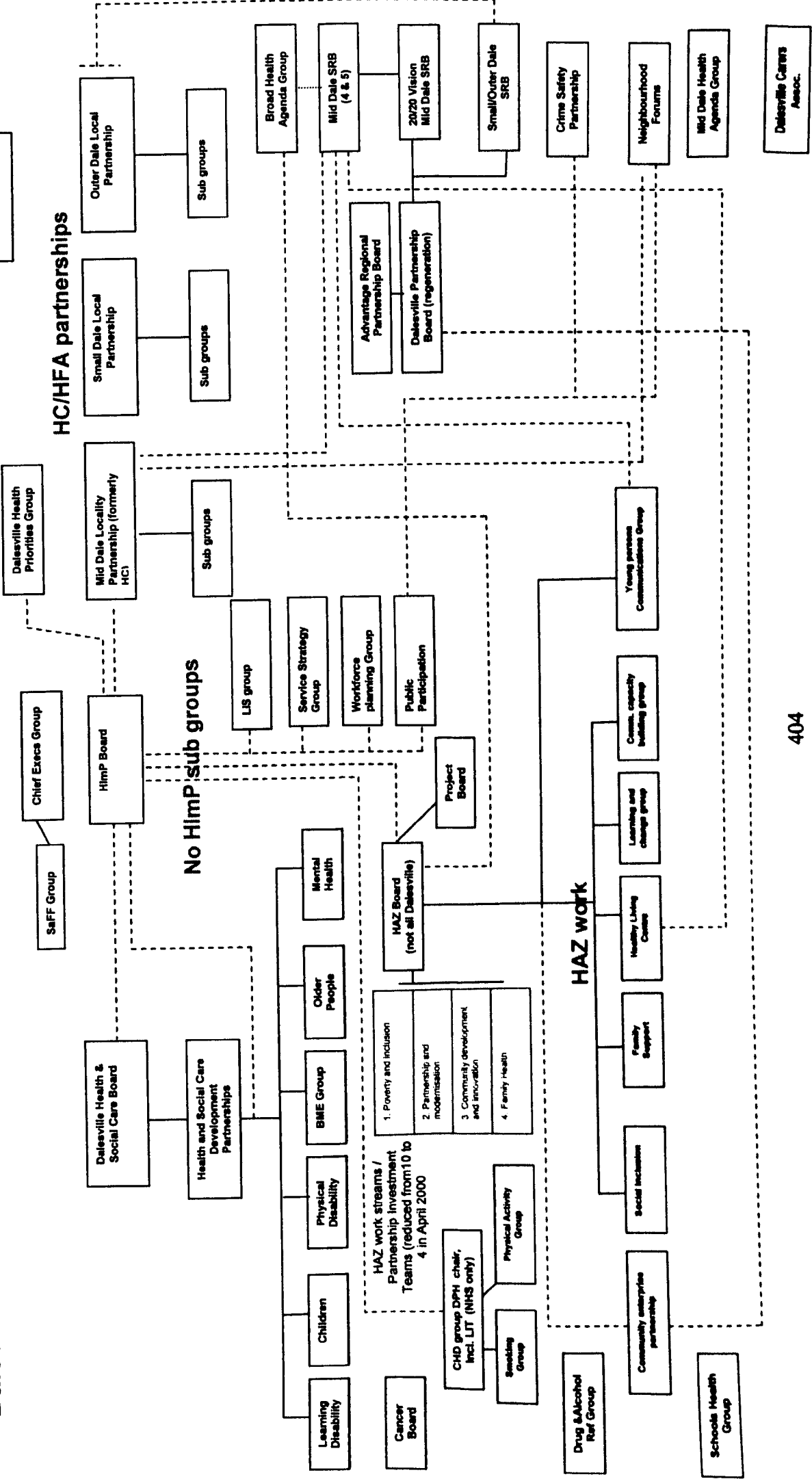
There are two types of line on each diagram. These represent formal and informal relationships:

Formal accountability link _____

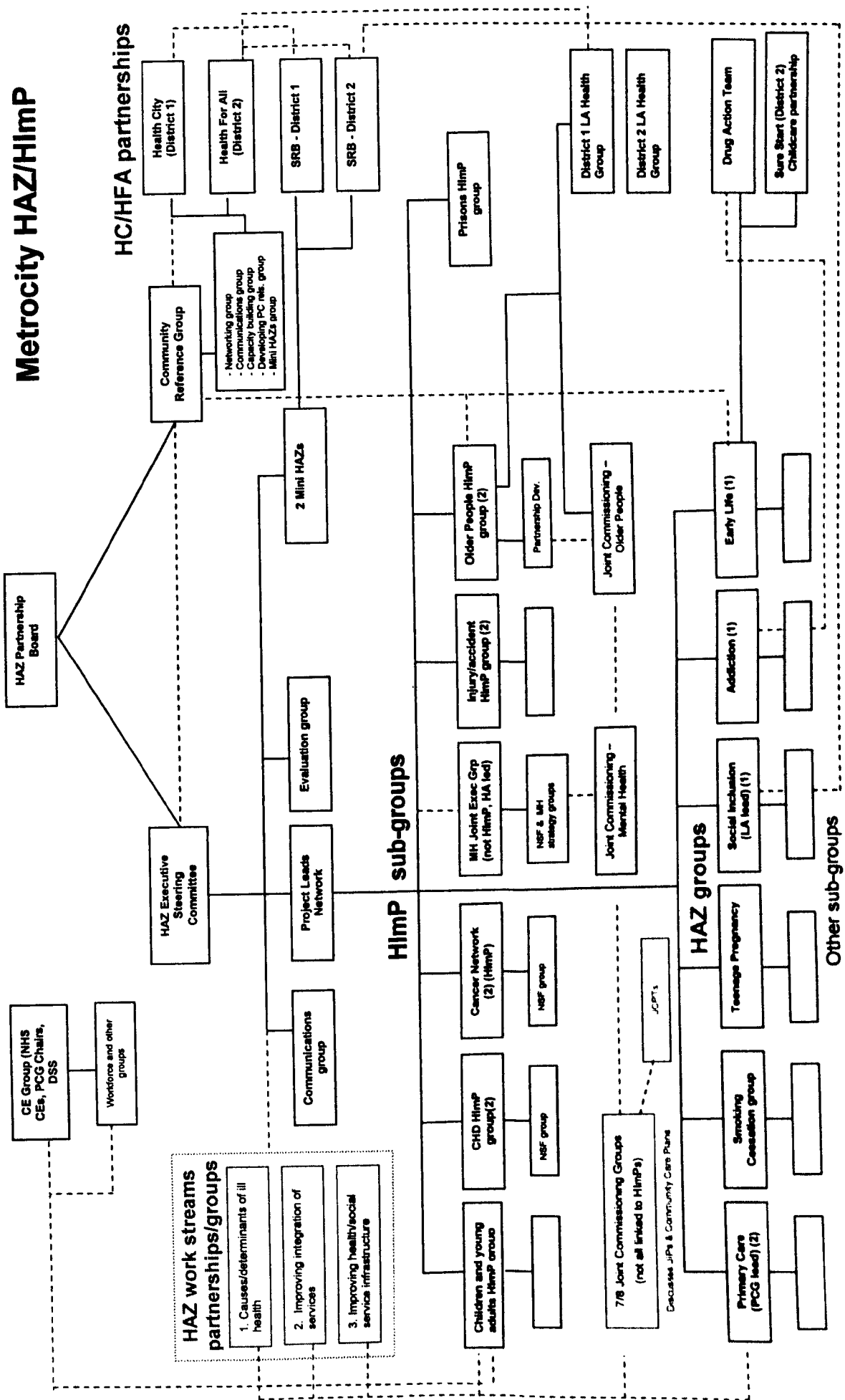
Informal link (i.e. members in
common) - - - - -

Dalesville HAZ/HImP

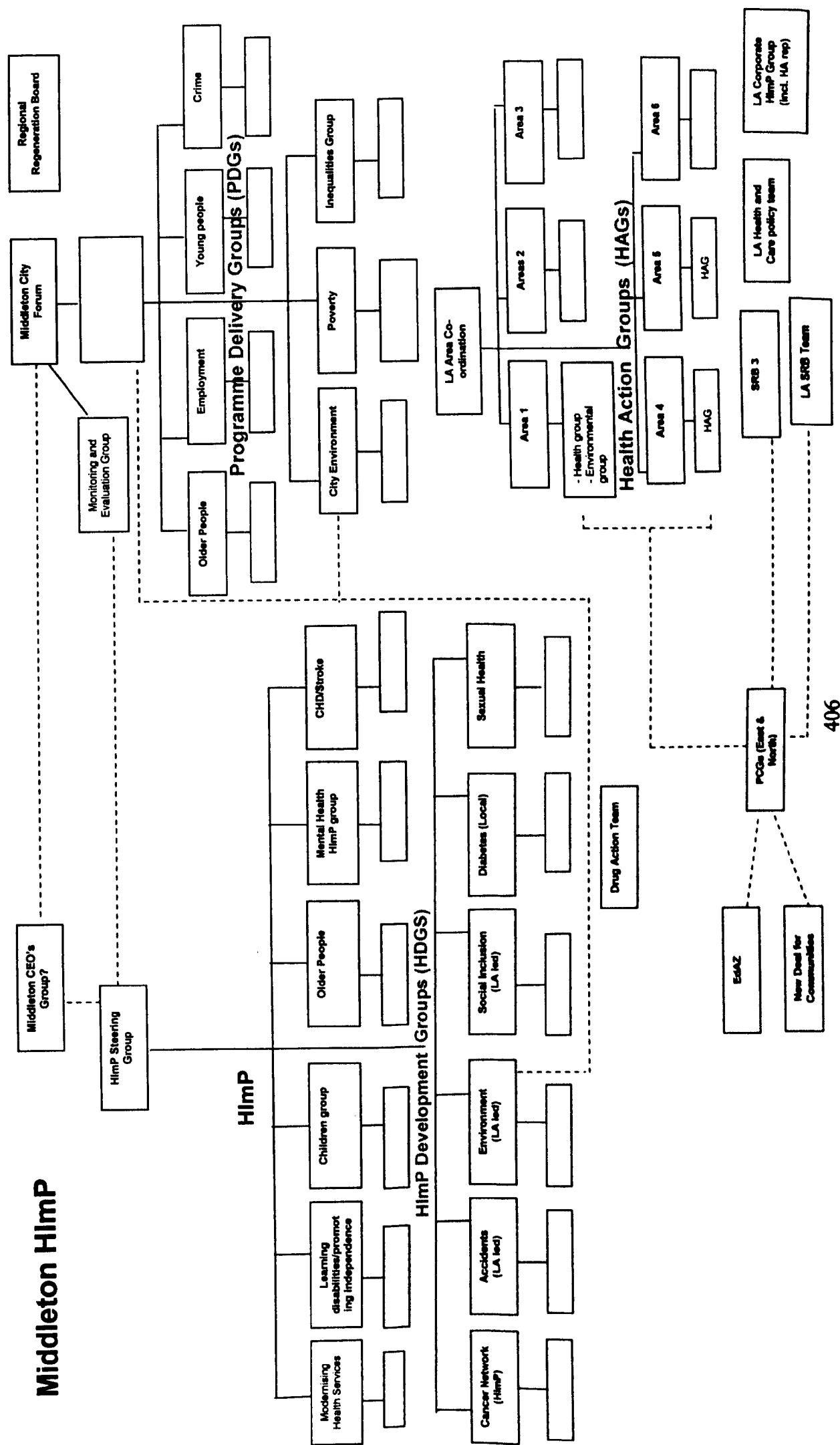
EAZ



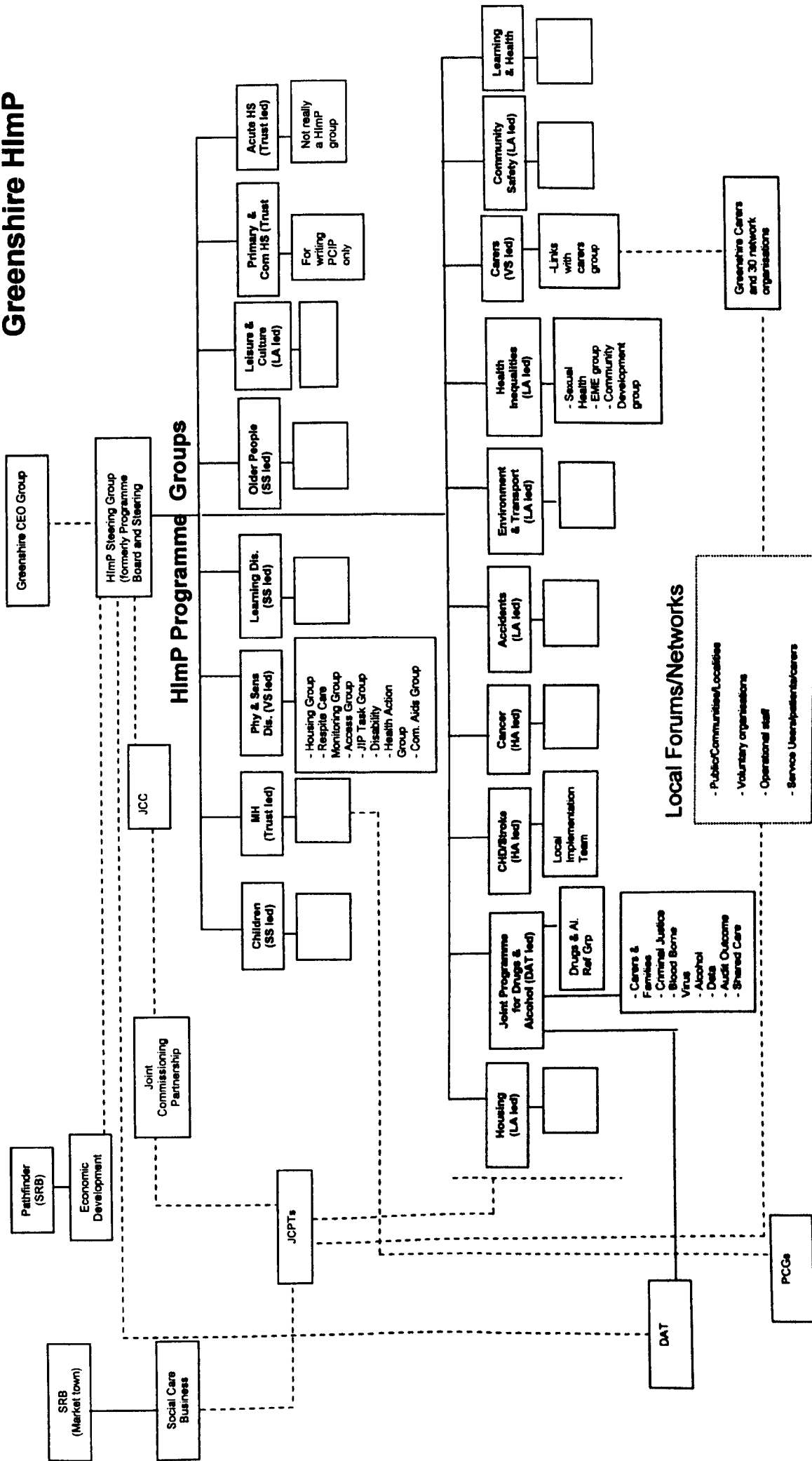
Metrocity HAZ/HImp



Other local partnerships



Greenshire HImp



Appendix O

Loxley’s framework for collaboration in health and welfare

Loxley’s conceptual framework for collaboration in health and welfare combines aspects of three theories of social interaction (namely *Systems theory*, *Social Exchange Theory* and *Co-operation Theory*) with the dimension of *power, culture and values* and *structure*. She argues that difficulties often experienced in collaboration are attributable to competition for power and resources, the defensiveness of holding on to what is known, understood and practiced and the impact of an unsupportive environment.

Failure to address all these elements has frustrated attempts to improve attitudes and relations through inter-professional education. Only through the explicit consideration of the effect of these elements can partnership become well-founded, effective and produce sustainable services responsive to need. This requires everyone participating in collaboration to possess the core skills needed for the development of the partnership process (Loxley 1997). A diagram of Loxley’s framework is shown below.

Social elements				Core skills
Culture and values	Independent and holistic	Accepting risk in cost/benefit	Trust and credit accumulation	Assessing resources
	Autonomy and sharing	Sufficient to be competent to engage and deliver	Sufficient to be <i>provocable</i>	Building structures
Structures	Open boundaries	Open and organised for exchange	Sustained and stable enough for the <i>shadow</i> of the future	Managing processes
	Systems Theory	Social Exchange Theory	Co-operation Theory	Evaluating outcomes
Theories of social interaction				

Source: (Loxley 1997)

Hudson's framework for the analysis of collaboration in social welfare

Hudson's framework for the analysis of collaboration in social welfare also draws on theoretical perspectives relating to interaction between individual and organisations (such as *resource exchange*, *network theory* and *Resource Dependency Theory*). He combines these concepts with insights taken from the empirical literature.

Hudson argues that collaboration must be viewed as an organisational network in a social welfare setting and analysed in relation to its external environmental (Sanderson 1990). Collaborative activity should be analysed, therefore, at three levels: the socio-economic level in which it is embedded, the attributes of the interacting organisations, and the nature of the links between them.

A 'turbulent' environment such as unstable social conditions, a new piece of legislation or a retrenching economy can affect an organisation's ability to function independently or create the context for organisational interaction. However, while clearly the environment is important, it is not sufficient to explain inter-organisational relationships (Hudson 1987). Here, Hudson takes a comparative properties approach, identifying attributes or dimensions of interacting groups or organisations in a network. These constitute a set of conditions that continually shape the pattern of interaction. He identifies five pre-requisites for the creation of collaborative activity (Hudson 1987; Sanderson 1990). These are:

- *Inter-organisational homogeneity*: the degree to which members of a network exhibit structural and functional similarity. Difference in value systems and goals can be an obstacle to work.
- *Domain consensus*: a set of expectations about what an organisation will and will not do, providing an image of the organisation's role in a larger system, which in turn serves as a guide for the ordering of action in certain directions. Consensus requires agreement and compatibility on specific organisational goals as well as philosophies and reference orientations. Domain consensus is important to establishing the legitimacy of an organisation and its claim on resources. Low domain consensus can hinder collaboration but so too can similarity of domains by promotion of competition.
- *Network awareness*: organisational interdependency is the most fertile ground for collaboration but this requires awareness of other organisations as well as the possibility of matching goals and resources. A positive evaluation of the value of other organisations' work is important to collaboration and is affected by historical relations and patterns of accountability and socialisation.
- *Organisational exchange*: exchange refers to interactions based on reciprocal re-enforcement i.e. it is perceived that the exchange is in each organisation's interest. Analysis must focus on power processes. Equality of power is not a pre-condition for exchange but it is important that neither party is powerless in relation to the other.

- *Alternative resource sources:* the availability of alternative 'outside' sources will reduce the incentive for an organisation to enter into exchange relations with other organisations in its network.

Hudson argues that these variables may help explain the degree of collaboration or conflict in interactions between organisations. He elaborates on the specific nature of collaborative links and suggests four dimensions for analysis (Hudson 1987; Sanderson 1990):

- *Degree of formalisation:*
 - i. Collaboration may be mandated by administrative or legislative sanction.
 - ii. The existence of an intermediate body to facilitate exchange and co-ordination. Where there is a high degree of independence or conflict, interdependence may have to be induced via modification to goals and use of resources.
- *Degree of intensity:* the amount of investment an organisation has in its relations with other organisations in terms of the amount of resources, the frequency of interaction and the level at which interaction takes place.
- *Degree of reciprocity:* the degree of symmetry or asymmetry in exchange transactions between organisations in terms of resources (money, physical facilities and material, information, client referral and such intangibles as prestige).
- *Degree of standardisation:* Standardisation of relation between organisations (in terms of, for example, units of measurement for resources and procedural arrangements that affect collaboration).

List of abbreviations

ADPH	Assistant Director of Public Health
BME	Black and Ethnic Minority
CEO	Chief Executive Officer
CHC	Community Health Council
CHD	Coronary Heart Disease
CMHS	Community Mental Health Services
CRE	Council/Commission for Racial Equality
CT	Community Trust
DETR	Department of Environment, Transport and the Regions
DoH	Department of Health
DC	District Council
DAT	Drug Action Team
DPH	Director of Public Health
DSS	Director of Social Services
EH	Environmental Health
EHO	Environmental Health Officer
HAZ	Health Action Zone
HC	Healthy City
HFA 2000	Health For All 2000
HImP	Health Improvement Programme
HIMP	Health Improvement and Modernisation Programme
HOTN	Health of the Nation
HP	Health Promotion
HSCB	Health and Social Care Board
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
JF	Joint Finance
JIP	Joint Investment Programme
LA	Local authority
LD	Learning Disability
LIFT	Local Improvement Finance Trusts
LIT	Local Implementation Team
MH	Mental Health
NHS	National Health Service
NOF	New Opportunities Fund
NVQ	National Vocational Qualification

OP	Older People
OPDM	Office of the Deputy Prime Minister
PbR	Payment by Results
PCC	Primary and Continuing Care
PC	Primary Care
PCG	Primary Care Group
PCIP	Primary Care Investment Plan
PCT	Primary Care Trust
PH	Public Health
PFI	Private Finance Initiative
RDT	Resource Dependency Theory
REC	Race Equality Council
SaFF	Service and Financial Framework
SDG	Service Development Groups
SS	Social Services
VO	Voluntary organisation
VS	Voluntary Sector
VSC	Voluntary Service Councils
WHO	World Health Organization